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ABSTRACT

The number of adolescents with AIDS and the number of young adults diagnosed with AIDS who were infected with HIV during adolescence continues to grow at alarming rates. This report evaluates a program that included staff development, mandated HIV/AIDS education for children in kindergarten through grade 12, and a peer leadership component that was designed to increase students' knowledge of HIV/AIDS issues. The evaluation appears in seven chapters. Chapter 1 provides an introduction and overview of the program. Chapters 2 and 3 describe program orientation, different levels of training, recruitment, and the accomplishments of the HIV/AIDS education teams, while chapter 4 addresses issues affecting mandated HIV/AIDS instruction and related educational efforts in high schools. Chapter 5 focuses on the first year of condom availability during the two phases of the program, and chapter 6 covers community program involvement and resource needs. The peer education program and Be Active in Self Education (BASE) grants are discussed in chapter 7. Evaluators offer recommendations at the end of each chapter. Also included are a glossary and appendices cataloging schools by implementation phase, program implementation guidelines, a self-assessment instrument, curriculum descriptions, and a list of participating community-based organizations. (RJM)

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ED 380 751

OREA Report

EVALUATION OF THE HIV/AIDS EDUCATION PROGRAM/INCLUDING CONDOM AVAILABILITY

1990 - 1992

CG026168

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EXECUTIVE SUMMARY

INTRODUCTION

New York City has more reported cases of AIDS among adolescents than any other city in the United States. The number of adolescents with AIDS and the number of young adults diagnosed with AIDS who were most likely infected with HIV during adolescence continues to grow at alarming rates. For every diagnosed case of AIDS, there are multiple cases of HIV-positive youth who may not know they are infected. Effective response to the HIV/AIDS crisis must collectively involve all of New York City's health, educational, and social service resources. Drawing on the school system's expertise and access to youth, Chancellor Fernandez introduced his Expanded HIV/AIDS Education Program/Including Condom Availability. The purpose of this program was to raise awareness about HIV/AIDS and to encourage students to abstain from high risk behavior, including sexual intercourse and substance abuse.

OREA's assessment of the implementation of the Chancellor's Expanded Program during the 1991-92 school year found substantial accomplishments. The New York City Public Schools conducted orientation and training for members of newly formed HIV/AIDS education teams in the system's 120 high schools and 17 programs. Teams consisted of school administrators, teachers, pupil support staff, students, parents, and staff of community-based organizations. Overall, participants found these trainings to be informative and useful. With feedback from approximately one-third of public high schools (including ten schools where OREA evaluators conducted extensive interviews), evaluators determined that the mandated provisions of this large-scale program were successfully implemented throughout the five boroughs in every type of school and program. Schools established broad-based HIV/AIDS education teams and set up health resource rooms. Six mandated HIV/AIDS lessons were taught by health and physical education teachers, other academic teachers, SPARK counselors, community-based organization staff, or some combination depending on the school. All teams held informational meetings for parents for the purposes of explaining the Program and responding to questions. HIV/AIDS teams implemented condom availability,* assigning volunteers to the health resource room and other accessible sites for a minimum of ten class periods each week.

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*In this program, condoms were available to students who request them from specially trained New York City public school employees. Condoms were not "distributed" to students who did not specifically request them. Condom availability occured within the larger context of HIV/AIDS prevention education including abstinence.

Multiple strategies were used to inform students about the locations and times of availability.

As a result of careful planning and administrative leadership, implementation of condom availability proceeded smoothly, with no discernable disruption to schools' programs and operations. Anticipated problems with community opposition or interference at the school level did not materialize. Most students reacted to condom availability in their schools with great maturity. According to those involved in the Program, one of the most important outcomes of the Program was improved communication between students and teachers about HIV/AIDS as well as a range of health and social issues of concern to students.

THE HIV/AIDS EDUCATION PROGRAM

HIV/AIDS education was first implemented in the City's public schools in 1987; and in 1989, then Chancellor Richard Green mandated a minimum of six lessons per grade of HIV/AIDS instruction in grades 7-12. In February, 1991, the New York City Board of Education voted to expand the program to include--in addition to classroom instruction--the establishment of HIV/AIDS education teams, condom availability at the high school level, student involvement, and parent information sessions. The program complies with State regulations and Regents' clarifications.

The Expanded HIV/AIDS Education Program/Including Condom Availability was initially coordinated by the Office of the Deputy Chancellor for Operations. (Currently the Program is administered by the Division of Student Support Services.) Day-to-day operations were conducted by the HIV/AIDS Technical Assistance Project, the SPARK (Comprehensive Health and Substance Abuse Prevention) Program, and the High School HIV/AIDS Program. Six Comprehensive Health Coordinators (CHCs) provided training and technical assistance and worked to link schools with community-based resources.

In March 1991, the Chancellor issued implementation guidelines requiring each high school to establish a broad-based HIV/AIDS Education Team and to develop individualized plans for program implementation. The New York City Public School System required team members to attend its Orientation and training sessions. In order to receive approval to begin condom availability, schools had to demonstrate their readiness to a site visit team from the central administration.

EVALUATION

During the 1990-92 school years, the Office of Research, Evaluation, and Assessment (OREA) conducted evaluation activities designed to document each component of the program. Given the importance of the Chancellor's expanded program, this report emphasizes activities occurring during the 1991-92 school year. During this school year, evaluation of the Expanded Program was conducted at three levels. At the school level, HIV/AIDS education teams were responsible for setting their own standards and measuring their progress toward meeting these standards. This assessment was to provide information for program improvement.

Another level of evaluation was that conducted by the Office of Research, Evaluation, and Assessment culminating in this report to program administrators and schools. Because the Expanded Program had just begun, the focus of this evaluation was documentation and implementation. Plans to address program impact on student behavior were planned for later years. Complementing these efforts, the Chancellor invited respected external researchers to evaluate impact in greater depth and assess other aspects of the Program. The Chancellor also welcomed proposals for the evaluation of promising high school-based interventions for reducing students' risks of HIV/AIDS that would enhance the Chancellor's program.

The goals of OREA's evaluation during the 1990-91 and 1991-92 school years were:

1990-91

- To assess the teacher training component during the 1990-91 school year, particularly with respect to the program's goal of integrating HIV/AIDS education within a more comprehensive school program.
- To assess the implementation of a peer leadership program in selected schools.

1991-92

- To document and assess the Expanded HIV/AIDS Education Program's training and resource development process.
- To provide formative feedback to program planners, administrators, and schools on implementation progress and barriers.
- To determine the Program's impact on students, teachers, and other school staff as well as on the school environment.
- To identify strategies associated with positive programmatic outcomes.
- To recommend changes for strengthening the program.

Sources of Data

Findings pertaining to teacher training during the 1990-91 school year are based on observations of five teacher-training sessions. Also during that year, OREA evaluators assessed the peer leadership program by collecting data at the general training for peer educators and by conducting interviews with peer leaders and faculty advisors during site visits to seven high schools and one junior high school.

The evaluation activities conducted in 1991-92 gathered data from three sources. One source was self-administered survey questionnaires completed by HIV/AIDS education team members after attending trainings conducted by the HIV/AIDS Office of Technical Assistance. A second source was 177 interviews conducted by OREA evaluators (with principals, school staff, students, and parents) during site visits to ten high schools in Phases I and II*. The schools in the site visit sample broadly represented the geographic and program diversity of New York City Public Schools. OREA, however, did not choose its sample of schools and individual interviews at random so findings cannot be generalized beyond the sample. A third data source was self-assessment reports submitted to OREA by 35 high schools.

OVERALL FINDINGS

Evaluation findings pertaining to the training sessions were disseminated to the Technical Assistance Project and the Comprehensive Health Coordinators shortly after the trainings to help inform the planning of subsequent sessions. Preliminary findings based on the site visits and self-assessment reports were formally presented to the Internal Working Group early in the summer of 1992 and informally in discussions between the evaluators and central program staff.

In this Executive Summary, overall conclusions and general themes emerging from the assessment are accompanied by conclusions pertaining to specific areas of the research. Recommendations for program improvement follow.

In 1990-91 the New York City Public Schools HIV/AIDS Education Program focused considerable attention on training teachers for instruction and peer education programs. With the expansion of the program in 1991-92, central staff devoted substantial effort to building HIV/AIDS education teams and responsibly implementing the condom availability component of the program. Teacher training for the HIV/AIDS lessons and curriculum issues received less attention than it had in 1990-91.

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* Schools were divided into three groups for staggered program implementation during the 1991-92 school year. Schools in the first two groups, Phase I and Phase II, were selected into the assessment sample.

By the end of the 1991-92 school year, the New York City public high schools had made tremendous progress in implementing the key provisions of the Chancellor's expanded HIV/AIDS Education Program. As already noted, each of the 10 schools in the site visit sample and the Phase I and II schools submitting self-assessment reports met the minimum requirements for developing HIV/AIDS education teams, staffing and stocking health resource rooms, teaching the six lessons, and conducting parent information sessions. As a result, condom availability implementation proceeded smoothly with students responding more maturely than anticipated; both student and staff responses to the program displayed mutual respect. Staff and students concurred that the schools' willingness to implement a program component as controversial as condom availability reinforced for students the serious threat that HIV/AIDS represents.

Several schools in the site visit sample exceeded the minimum requirements and developed active, high profile programs. In these schools, there was evidence of active student involvement, as demonstrated by murals, hallway displays and student-designed posters. In one of these schools, where the six mandated lessons were integrated into academic subject classes, teachers received in-service training on HIV/AIDS. Following classroom instruction, teachers debriefed with their department chairs about their experiences teaching the lessons. In these more active schools, condoms were generally made available to students in multiple sites, throughout the day.

Moreover, community-based organizations augmented school programs in significant ways, for example, through teaching one or more of the mandated lessons, through performances, by working with students on BASE Grants,* and serving as resources to students for health and social services. OREA did not attempt to identify the reasons that some schools developed active, high profile programs, while others only implemented the minimal program that was mandated. One possible explanation is that schools with high profile programs built on activities and relationships that predated the Expanded HIV/AIDS Education Program. In this case, additional experience, training and technical assistance may assist the low profile programs in strengthening and improving their programs. Future evaluation will continue to explore the conditions fostering effective programs.

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* The BASE grant program--Be Active in Self Education--is a privately-funded small grants program for student-developed HIV/AIDS and other health-related programs.

Perhaps in part because a number of alternative schools had already initiated their own responses to the HIV/AIDS crisis prior to the Chancellor's Expanded program, program guidelines were targeted to traditional school settings. Alternative schools, however, experienced difficulty in several areas. Staff from several alternative school programs indicated that sending teachers to the training created disruptions in their schools. In addition, mandates for establishing teams and health resource rooms were not always appropriate, particularly for multi-site schools. Program guidelines stipulated that schools submitting requests for reasonable adjustments in their plans could obtain waivers from any of the program mandates.

Team members received HIV/AIDS updates in the training sessions and in packets of information assembled and disseminated by the CHCs. The central office also disseminated copies of Karen Hein's book, *Trading Facts for Fears*, and teams were encouraged to contact the High School HIV/AIDS Resource Center located in a Manhattan alternative high school. Nevertheless, many staff interviewed expressed the need for updated information on HIV/AIDS, particularly in the areas of medical advances and public health. Staff wanted this information disseminated routinely after programs were implemented either through additional training or other means (e.g. a newsletter or E-mail). They also wanted curriculum materials updated and new information reflected in the written materials developed for students.

The importance of student involvement in all aspects of the HIV/AIDS education program emerged throughout the evaluation. Students who were interviewed spoke very articulately about aspects of the program that worked and those that needed improvement. Participation on the HIV/AIDS education team was associated with students' beliefs that the program was having a positive impact on prevention. Students provided outreach about the program to their peers and were sources of information about HIV/AIDS prevention.

Finally, during this first start-up year, OREA necessarily focused its evaluation on program implementation rather than the impact of HIV/AIDS education and condom availability on changes in students' knowledge, attitudes, and behaviors. Several preliminary outcome findings emerged from OREA's evaluation. For example, a number of staff indicated that the HIV/AIDS lessons made it easier for students to talk to each other and to teachers about prevention including abstinence. Others believed the identification of specific teachers as health resource staff helped students feel more comfortable talking with them about personal problems and concerns. As a result, school staff and administrators were much more aware of students who were personally affected by HIV/AIDS in their families. Several multiyear, external evaluation projects coordinated by OREA are designed to determine the program's impact on students in these and other areas.

TRAINING

Background

In order to ensure the success of the program, the New York City Public Schools conducted a series of training sessions for staff, students, health care providers, and CBO staff who volunteered to serve on the HIV/AIDS Education teams in each school. The Office of Health hired a training director to coordinate the HIV/AIDS training committee as well as six full-time Comprehensive Health Coordinators to work with each of the Borough Superintendents and alternative high schools.

Program administrators assigned schools to one of three phases of training for the 1991-92 school year based on their readiness for implementation as reflected in their HIV/AIDS plans. There were 16 high schools and one program in Phase I, 53 high schools in Phase II, and 51 high schools in Phase III.

Training consisted of three sessions. The first session, a half-day Orientation, was designed to create a context for the program, provide current information on the impact of HIV/AIDS on adolescents, and provide team members an opportunity to share concerns about their roles in the program. The second session, the full-day Tier I training, covered State regulations and Regents' clarifications, Board of Education policies, facilitated team-building, and sought to introduce team members to external resources. Tier II was the third and final session. This two-day training consisted entirely of small group exercises, specifically designed for health resource staff. Accordingly, only full-time New York City public school staff members on the teams were permitted to attend. This training covered: skill building; information on adolescent sexual behavior including abstinence; condom use and misuse; and policy review.

Findings

Overall, the training received positive ratings from both survey respondents who completed questionnaires immediately after training and site visit interviewees. Among interviewees, 77 percent rated the training as either "very useful" or "somewhat useful." Survey respondents were even more enthusiastic, with between 70-90 percent finding each segment of the training either "very useful" or "somewhat useful."

As to specific training activities, 32 percent of the interviewees and 47 percent of Tier I survey respondents gave positive ratings (i.e. "very" or "somewhat useful") to team-building activities, and 31 percent of the interviewees and 41 percent of the Tier II respondents rated the HIV/AIDS updates positively. Approximately one fourth reported that the condom demonstrations were "very useful" and another half (51%) thought them to be "somewhat useful." Additionally, between 30 and 37 percent of survey respondents rated the Board of Education policy updates as "very" or "somewhat useful."

In regard to problems with the training, some interviewees thought that it could have been better organized; however, the analysis did not differentiate between responses by those attending Phase I and II training, and organization may have improved by Phase II in response to changes made by the training staff.

Training was designed to ensure that all team members develop a minimum knowledge base about HIV/AIDS and the program, and that they become aware of their own feelings about HIV/AIDS issues. Consequently, it was not surprising that 22 percent of interviewees--mostly staff with prior experience with HIV/AIDS education--indicated that the training had been too elementary for them.

When asked for suggestions to improve future trainings, 21 percent of interviewees suggested that more factual information on HIV/AIDS would have made the sessions more useful to them, and 15 percent would have liked more emphasis on family counseling techniques.

Ongoing training needs identified by respondents included: continuing updates on HIV/AIDS issues, how to counsel HIV-positive students and their families, additional information on adolescent development, and how to address cultural diversity in HIV/AIDS education. Seventy-eight percent of Tier II respondents also asked for additional advice on ways to increase support for their HIV/AIDS programs.

HIV/AIDS EDUCATION TEAMS

Background

Program guidelines required that every school form an HIV/AIDS education team that would be responsible for planning and facilitating the educational program and the condom availability plan. According to the Chancellor's mandate, team composition was to include the principal, an assistant principal, at least one teacher, one student, one parent, and health resource staff. Guidelines also suggested that team membership be extended to others in the school community including social workers, guidance counselors, SPARK intervention specialists, and special education staff. By encouraging the establishment of broadly-based teams and promoting the expansion of HIV/AIDS education beyond health education classes to academic subject classes (as discussed in the following section on the HIV/AIDS curriculum), the Expanded Program was designed to mobilize the resources of the school community to address this serious epidemic.

Findings

All of the schools established teams that were, for the most part, broadly representative of the school community. Principals selected a staff member or administrator to serve as team leader and in one case a parent was selected. The teams ranged in size from 10 to 40 members and the percentage of team members who were health resource staff ranged from 21 to 100 percent. Seven of the 10 team leaders interviewed by OREA evaluators indicated that their teams increased in size during the 1991-92 school year, and three teams lost members. A few principals expressed concern that parents were underrepresented on teams, although their involvement, reportedly, was no lower than was typical for other high school programs. Daytime meetings created obstacles for participation.

All 10 principals rated the overall functioning of the team as "excellent" and attributed this primarily to the commitment of the team members. Staff members indicated that they were motivated to serve on the team because of their concern for their students and their strong desire to halt the spread of HIV infection. Some health and science teachers said that their participation was a natural outgrowth of their own professional interests.

In general, team members expressed enthusiasm about their involvement in the program, and cited the dedication and commitment of fellow team members as the reason for these feelings. The teams' work reportedly was also facilitated by leadership qualities of the team leader, support from the school administration, and intra-group rapport.

Teams thought that the major obstacles to team functioning were the logistical difficulties of meeting times and the lack of release time for HIV/AIDS team meetings. Since membership was voluntary, teams met on their own time, either before or after school or during lunch hours. A few team members also identified as an obstacle their need for more, updated materials for students.

As mandated, all of the teams held informational meetings for parents for the purpose of explaining the program and answering parents' questions. Self-assessment reports identified a wide range of activities conducted by the teams to increase student awareness about HIV/AIDS. Four teams indicated that they conducted an AIDS Awareness Week, three reported organizing health fairs, and three others said they supervised student poster and mural projects.

OREA found that most students thought the HIV/AIDS Education Program was having a positive impact in three areas: increasing the likelihood that students would get HIV counseling or testing, opening up communication between students and staff with respect to student health concerns, and increasing the use of condoms among sexually active students. Student members of the HIV/AIDS teams thought that the program had a more positive impact than did students who were not team members.

IMPLEMENTATION OF THE HIV/AIDS CURRICULUM

Background

In 1987, the Board of Education's Office of Health, Physical Education, and School Sports received funding from the federal Centers for Disease Control to expand the HIV/AIDS education program to six lessons per grade each year. To ensure that these lessons were being implemented, the Chancellor's Expanded Program made these six lessons mandatory. The newly established HIV/AIDS Technical Assistance Project office was responsible for the administration of curriculum implementation during the 1991-92 school year. To underscore the far-reaching impact of the HIV/AIDS epidemic and to involve much of the school community in HIV/AIDS education efforts, the program's founders sought to extend HIV/AIDS instruction beyond health education classes to academic subject classes such as science, social studies, English, and math. Accordingly, the Chancellor's guidelines recommended that schools integrate the subject of HIV/AIDS into as many academic subject areas as possible.

Findings

OREA determined that substantial HIV/AIDS education efforts took place during the 1991-92 school year in New York City public high schools. HIV/AIDS education teams moved forward in developing more effective educational programs that reached a larger number of students than in previous years. These educational programs included classroom instruction as well as other educational activities such as BASE grant projects, peer education, and other HIV/AIDS awareness programs.

Overall, curriculum coordinators praised the quality of the curriculum they used--primarily the 1989 HIV/AIDS Supplement to Family Life Curriculum--but virtually all staff members reported that rather than strictly adhering to the curriculum, it was a "jumping off point."* Four of the 10 coordinators reported supplementing these lessons with teaching ideas culled from the New York State Education Department's *Health AIDS Instructional Guide: Grades K-12*. In addition, half of the schools used lessons from the five-session SPARK HIV/AIDS Education Supplement to satisfy the six-lesson mandate, as well as to provide additional instruction. Although three coordinators praised the Family Life curriculum as "excellent," three others criticized it as "outdated" and containing insufficient information about women and AIDS. OREA evaluators found that even within the same school, teachers held opposing opinions about the curriculum.

There seemed to be some question as to how successfully the HIV/AIDS curriculum was being integrated into academic subject classes. Although eight of 10 curriculum coordinators reported that the curriculum was taught in regular academic subject classes other than health, instruction was frequently provided by health and physical education teachers and SPARK specialists. Although these may be the best trained staff to teach HIV/AIDS lessons, this placed a heavy burden on the health and physical education departments.

It appeared that some academic teachers interpreted the policy of "integrating" HIV/AIDS into their classes as using HIV/AIDS issues to illustrate their regular subject area lessons or suggesting HIV/AIDS-related topics for homework assignments. While this reflected the positive potential of teachers to heighten students' awareness about HIV/AIDS, it was unclear to OREA evaluators whether these secondary references to HIV/AIDS were being used to fulfill rather than supplement the six lesson requirement. Thus, some students may not be receiving the benefit of a mandated six lesson curriculum focused specifically on HIV/AIDS.

Evaluators found that school staff used a variety of strategies for providing HIV/AIDS instruction to the Limited English Proficiency (LEP) student population. In two of the 10 schools visited, the bilingual SPARK specialists taught the Spanish-speaking LEP students and at another school all lessons were translated into Spanish and Mandarin Chinese.

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*An updated curriculum for grades 7-9 is being reviewed by the Board of Education's HIV/AIDS Advisory Council and a revised high school curriculum is being written.

Teachers attempted to reach absentees and over-the-counter* late enrollee students through presentations in the cafeteria during lunch periods and with scheduled make-up lessons. One team leader noted that her school's policy of conducting monthly HIV/AIDS lessons meant that over-the-counter students were more likely to be reached since instruction occurred throughout the year.

Asked to rank how much they knew about HIV infection and AIDS both at the beginning of the 1991-92 school year and at the time they were interviewed, a large percentage of student respondents (63 percent) showed increases in their reported knowledge. An additional 19 percent reported beginning the school year knowing "a great deal" about these topics. A larger percentage of student team members reported gains in knowledge than non-team members. Student team members were also more likely than non-team members to think the educational program had an impact on their peers.

CONDOM AVAILABILITY

Background

Program mandates stated that schools designate at least one area in the building to make condoms and other health resources available to students. It was also required that this site be staffed at least ten periods per week by at least one male and one female school employee. Additional mandates included having all health resource staff participate in the program's special Tier II training and having schools post a schedule of the hours and locations of condom availability that was accessible to all students. Although there was no stipulation in the implementation mandates about the number of condoms to be given to students on request, all of the schools visited by OREA staff had a policy of giving out no more than two condoms at a time.

The first of the 17 Phase I schools began making condoms available in November 1991. Phase II schools began in January 1992. By June of 1992, all but 11 of the high schools that participated in the training had made condoms available to students.

Findings

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*"Over-the-counter" is the term applied to students who were not in the New York City School System the previous year and therefore were not listed on official high school records. These students did not register for school until September or later in the school year.

Implementation of condom availability occurred more smoothly than expected in each of the 10 schools visited by the evaluation team. Four principals reported being pleasantly surprised that students acted with maturity, seriousness, and dignity when condom availability began in their schools. There was no overt controversy at any of the schools visited and little interference by the media. Principals reported that parent opposition was minimal and that they responded to parents' fears and concerns on a one-to-one basis. Several principals indicated that one obstacle they faced in program implementation was finding space for health resource rooms in their already overcrowded schools.

All of the schools posted the Health Resource Room schedule, with the exception of the multi-site alternative school where condoms could be obtained only from the site teacher. There was no consensus among students about the most effective way to inform them about condom availability. This suggested that multiple strategies were needed to reach different student groups.

In both the self-assessment and site visit samples approximately two-thirds of health resource staff were female and one-third were male. The total number of volunteers ranged from three to 30 in the self-assessment and site visit samples with a median of ten volunteers. Among vocational-technical and academic-comprehensive high schools, those with the greatest number of volunteers had active, high profile programs, while schools with fewer volunteers tended to have low visibility programs that were more narrow in scope.

Although teams sought to have health resource staff who represented the racial and ethnic diversity of the school, students appeared to select volunteers on the basis of the rapport they felt they had with them, rather than upon volunteers' race or ethnicity. The health resource staff's personalities and backgrounds in health and sexuality education or guidance and counseling may have made them more approachable rendering their racial or ethnic status, of secondary importance.

OREA found that of the 10 schools visited, only two had a single designated Health Resource Room dedicated exclusively for dissemination of health information and condom availability. An important finding was that both school staff and students reported that the consequence of having a single site was that it became known as the "condom room," and students seeking information sometimes avoided the room for fear of being identified as sexually active. This was particularly true for female students. Further, the mandate requiring health resource rooms was impractical for the multi-site alternative school, where students combined academic work with on-the-job training at locations throughout New York City.

Eight of the 10 schools visited and most of the self-assessment sample schools designated several satellite sites as places students could obtain condoms. These included the offices of guidance counselors, SPARK specialists, physical education departments, and the COSA (Coordinator of Student Affairs). Students were unable to obtain condoms at school-based clinics pursuant to a Board of Education prohibition against the availability of birth control at such clinics at that time.*

Students' comfort in requesting condoms from particular individuals also appeared to be more important than the actual location of condom availability. Five students specifically mentioned that the reason they preferred a particular location was the person, rather than the site.

Schools with only a single-purpose health resource room had the most limited number of availability hours. Staff in one of the smaller schools with one health resource room tended to serve a small number of students. These staff complained that sitting in the little used health resource room was not a productive use of their time and they indicated that they were reluctant to volunteer the following year. In contrast, volunteers in other schools were happier when classrooms and offices were designated as satellite sites. This also expanded availability enormously since teachers and staff could be found in these sites several periods a day. Moreover, this enabled volunteers to accomplish other duties if students were not requesting condoms.

Health resource staff reported that requests for condoms were brisk when they first became available, but slackened when the "novelty" faded. Fifty-five percent (N=22) of the volunteers said requests were initially high and then decreased. Some staff thought that decreases in requests were a result of an increase in abstinence, however, other staff reported concern about continued high numbers of pregnancies at their schools. Of grave concern to volunteers were the low numbers of requests for condoms in light of the high numbers of adolescents who, according to published research, were sexually active.

The program specifically mandates classroom HIV/AIDS Education but there are no mandates for counseling students when they request condoms. Nevertheless, health resource staff were trained in how to be responsive to student questions and concerns. With regard to HIV prevention, volunteers were instructed to emphasize that the only 100 percent effective way to prevent the sexual spread of HIV and other STDs is to abstain from sexual intercourse and that there are risks to using condoms. If condoms were requested, volunteers were also instructed to hand students a manufacturer's instruction sheet and a card listing the risks of use and misuse of condoms. Volunteers reported that students rarely requested information from them when asking for condoms, although some volunteers indicated that they made a point of engaging students in discussion to ensure that they knew how to use condoms properly. Some students returned at other times to request information or to talk. In addition to ensuring that some of the sites for condom availability provided a measure of privacy, staff believed it important to create opportunities for discussion and questions in classes and at HIV/AIDS events.

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*School-based clinics were permitted to make condoms available pursuant to Resolution 26 passed at the September 16, 1992 Board of Education meeting.

Over the course of the site visits, evaluators gained the impression that on the topics of HIV/AIDS and sexuality, the lines of communication had opened significantly between student and program staff. Students found opportunities to talk to school staff apart from condom transactions. One team leader said that the program provided an opportunity for students to talk with staff about sexuality and drug abuse issues. Another said that the program gave students with HIV-positive family members someone with whom to talk. One staff member described condom availability as a "carrot" used to engage students in discussion.

COMMUNITY-BASED ORGANIZATION INVOLVEMENT

Background

The Chancellor's implementation guidelines encouraged the continued involvement of community-based organizations (CBOs) in the Expanded HIV/AIDS Education Program.

Findings

CBOs enriched the Expanded HIV/AIDS Education Program in many ways. For example, they were instrumental in planning and conducting the HIV/AIDS team training. They were also actively involved in high schools as members of the HIV/AIDS education teams and through theater performances, peer education programs, and as resources for speakers, materials, and referrals.

Community-based programs were involved in nine of the ten schools in the site visit sample and six of these schools had a history of involvement that predated the Expanded Program. Most of the participating organizations in these schools were HIV/AIDS-related social service organizations. Public health agencies, hospitals and health clinics, were also popular choices. School staff requested help in overcoming barriers to participation including finding funds to pay for CBO presentations and streamlining the CBO approval process, centrally.

Principals and team leaders mentioned ongoing needs for CBO-related resources and materials. They requested speakers for student assemblies and parents' meetings. Almost half of the respondents asked specifically for presentations by persons with AIDS. Respondents also requested more information about community-based organizations where they could direct students and families with HIV-related needs.

CHCs and technical assistance staff worked with school HIV/AIDS teams to identify and obtain helpful materials for instruction, resource rooms, and other purposes. When materials could not be provided directly, team members were referred to the HIV/AIDS Resource Center and other agencies named on a resource list. Nonetheless, staff members, students, and parents voiced a need for updated HIV/AIDS educational materials including pamphlets, brochures, posters and videos, in appropriate languages. CBO's were seen as another source for these materials.

PEER EDUCATION AND BASE GRANTS

Background

Peer education has been an important component of the HIV/AIDS Education Program. In 1990-91, peer educators in high schools and junior high schools were trained by the central administration as part of a Peer Leadership program. BASE Grants were initiated in 1992 to expand student involvement in the area of adolescent health with a special focus on HIV/AIDS and drug and alcohol prevention.

Findings

On the basis of interviews with peer leaders (who received special training) and their faculty advisors, OREA evaluators concluded that peer leaders were important sources of factual information about HIV/AIDS for their fellow students and families. In addition to classroom instruction, peer leaders engaged in other activities to increase HIV/AIDS awareness, including health fairs, skits, public service commercials broadcast in schools, and schoolwide assemblies.

BASE Grants provided a vehicle for continued student involvement in health education activities. In 1991-92, under this initiative, 86 projects were funded in 62 schools by a private foundation. The site visit sample included four schools with BASE grants. The four students and four faculty advisors interviewed who worked on grant-funded activities were very positive about the projects. Student involvement--in some cases sparked by a personal attachment to someone with AIDS--was considered to benefit the student personally. Moreover, their projects benefitted students in their own schools though media outreach and, in the case of a school that hosted the citywide conference of peer educators, the effects extended beyond the funded schools.

RECOMMENDATIONS

Based on its assessment of the HIV/AIDS Education Program in the New York City public schools, OREA offers the following recommendations:

Staff Development

- Empower schools to play a larger role by increasing team involvement in the design and execution of future training events. To address the need for updates on medical and policy issues, teams should also be encouraged to organize staff development activities in their own schools. Moreover, this might be one way to build program support.
- Consider holding shorter, more frequent training events and make them more focused and intensive.
- As part of Tier I and Tier II training, conduct workshops or other activities designed for the more advanced participants who already possess solid backgrounds in the areas of HIV/AIDS and adolescent health.
- Provide more training for staff who teach the six mandated HIV/AIDS lessons. For example, enhanced teacher trainings could be conducted, preferably within each school, led by master teachers who have been identified by central administrative staff. Ensure that all teachers of HIV/AIDS lessons are properly trained and comfortable with the curriculum.
- Ensure that teachers who are participating in the program receive timely updates on HIV/AIDS issues and medical developments. In addition, provide training opportunities for teachers who would like to become involved in the program.
- Ensure that the Family Life Curriculum, scheduled to be updated for 1993, is reviewed on a regular basis so that it reflects the changing demographics and most recent medical developments concerning HIV/AIDS. For example, since the high school curriculum was developed in 1987, women infected with HIV through heterosexual contact have made up an increasing proportion of AIDS cases. As a result, women's issues and concerns should receive special attention in future curriculum revisions.

- Develop a long range plan for teachers to receive routine updates on HIV/AIDS issues and medical developments and ensure that new staff receive training that goes beyond the original mandates. Update the family life curriculum regularly and ensure that women's issues and concerns are

Staff Support

- Ensure that there is immediate information for principals and team leaders whenever an important HIV/AIDS policy change is imminent.

- Give more recognition to team members who are volunteering for the program without release time. Suggestions for formally recognizing team members' contributions include: special luncheons or dinners, staff retreats, or assisting them in becoming certified HIV/AIDS educators. Regularly acknowledge the commitment of volunteers on the HIV/AIDS education teams to reinforce their continued participation in the program.

- Help team leaders develop school-based accountability procedures to ensure that HIV/AIDS lessons are being taught as mandated. Encourage schools with effective educational programs to work with schools with less well-developed programs. Pair experienced HIV/AIDS educators--from the same or different schools--with inexperienced subject area teachers to improve HIV/AIDS instruction.

Program Components

- Clarify the policy related to integrating the HIV/AIDS curriculum into academic subject classes. In some schools secondary references to HIV/AIDS issues in classes with other primary goals may have been used in place of, rather than as supplements to, the recommended six-lesson curriculum. Clarification is needed about the content of the HIV/AIDS curriculum that will satisfy the Chancellor's mandate for teaching the six lessons.

- Extend the program mandates and guidelines to reflect the special conditions in alternative schools and special programs.

- To overcome one of the obstacles to parent involvement, teams may want to consider holding some meetings early in the morning, in the late afternoon, or in the early evening.

Materials and Outreach

- Accelerate the materials review process, implemented in 1992, to provide all schools with adequate and updated publications, videos, and other resources. Ensure that these materials are culturally relevant and in appropriate languages.

- Develop better methods to keep team members informed about continuing HIV/AIDS-related developments. Some suggestions include publishing a monthly HIV/AIDS newsletter, developing an accessible computerized database of HIV/AIDS articles, and initiating an HIV/AIDS E-mail "hotline" to handle team members' questions.

- Encourage and facilitate linkages between schools and community-based organizations and other voluntary organizations and agencies. Schools can benefit from the resources of external organizations with expertise in health care, HIV/AIDS, adolescent services, and other related areas. Reciprocally, schools can play an important role in informing students about the services available to them in the community.

- Assist schools in identifying appropriate speakers, especially people with AIDS or those who may be HIV-positive as well as speakers with medical backgrounds who can provide ongoing information to school staff, students, and parents about the HIV/AIDS epidemic.

Student Participation

- Foster the involvement of students on the HIV/AIDS education teams and expand opportunities for student involvement in HIV/AIDS education and awareness activities. Seek funding to expand the BASE grant program which provides funding for student-initiated projects. Because students seek each other for advice and information, and because they have a unique ability to craft prevention messages that will be meaningful to other students, their involvement in planning and programming should be encouraged.

- Provide more training to help some health resource staff become more "askable" and sensitive to students' concerns. Work with staff to create a climate in health resource sites that is comfortable for students who want to talk about a matter of importance to them or to obtain more information. This includes ensuring that there are private spaces for conversations between students and staff.

- Encourage the establishment of multiple sites for condom availability in schools in locations that are accessible to all students. Program planners should stress to schools the importance of ensuring that many of these sites be conducive to private conversation between student and volunteer.

- Expand opportunities for student involvement in HIV/AIDS programs. Student participation can be strengthened by an expanded role in outreach, dissemination of information, peer education, and leadership training.

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This report was prepared by the High School Evaluation Unit, Office of Research, Evaluation, and Assessment (OREA) of the New York City Public Schools. Dr. Lori Mei, Evaluation Manager, provided overall guidance for the evaluation project. Linda Simkin and Peggy Lane, evaluation consultants, shared responsibility for research design, data collection, and analysis. Additional members of the evaluation team--John Berman, Basima Ahed, and Clara Haignere--conducted site visits and interviews and analyzed selected issues. Linda Simkin, Peggy Lane, and John Berman were the principle report authors.

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Additional copies of this report are available by writing to:

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I. INTRODUCTION

The Expanded HIV/AIDS Education Program/Including Condom Availability was launched with a vote by the Board of Education on February 27, 1991, for implementation in the schools beginning in the 1991-92 school year. The program included staff development and mandated HIV/AIDS Education for children in kindergarten through grade 12, with six lessons per grade per year in grades seven to 12.* The Expanded program also included a condom availability component at the high school level which did not require parental consent or notification.

In 1990-91, the year prior to implementation of the Expanded Program,some schools' HIV/AIDS programs included HIV/AIDS education and staff development. In addition, a peer leadership component was designed to increase students' knowledge of HIV/AIDS issues, by training a core group of students to become mentors in AIDS education classes and to provide overall leadership in HIV prevention efforts in their schools.

The Expanded Program was initially administered by the Office of the Deputy Chancellor for Operations. Currently the program operates under the direction of the Division of Student Support Services in collaboration with the externally funded

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*Regulations issued by the State Education Department in 1987 mandated a K-12 instructional program on HIV/AIDS. In 1989 then Chancellor Richard Green issued a memorandum mandating that students in grades 7-12 receive a minimum of six lessons per grade of HIV/AIDS instruction. Although the New York City public schools had never adopted an official curriculum, a pilot curriculum was used.

HIV/AIDS Technical Assistance Project.* Coordination among these and other offices was achieved through regular meetings of the Internal Working Group.** Six Comprehensive Health Coordinators were responsible for providing training and technical assistance, and coordinating community resources.

Evaluation has been an integral part of the Expanded HIV/AIDS Education Program as well as the AIDS education and student peer leadership efforts that preceded it. Accordingly, during the 1990-91 and 1991-92 school years, the Office of Research, Evaluation, and Assessment (OREA) conducted evaluation activities to document these components and assess program implementation. The overall purpose of OREA's evaluation is to provide feedback to program planners and policymakers as the initiative evolves.

This report describes the staff development and student peer leadership programs conducted in 1990-91 and assesses the implementation of the Expanded HIV/AIDS Education Program/ Including Condom Availability during the 1991-92 school year.

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*The HIV/AIDS Technical Assistance Project is an externally funded project working within the New York City Public School System to provide training and technical assistance to the Expanded HIV/AIDS Education Program.

**The Internal Working Group on HIV/AIDS was established to ensure cooperation and coordination among the offices within the New York City Public School System that were involved in the program. The following offices are represented in this group: Chancellor's Office, High School Division, Chief for Instruction and Professional Development, Division of Student Support Services, HIV/AIDS Technical Assistance Project, Division of Public Affairs, High School Guidance, Division of Special Education, Substance Abuse Education, Office of Research, Evaluation, and Assessment, and Office of Parent Involvement.

Given the importance of the Chancellor's Expanded Program, the emphasis of this report is on activities occurring during the 1991-92 school year.

PROGRAM BACKGROUND

The alarming spread of HIV infection among adolescents has signaled the need for immediate, effective, and multifacited interventions. As of December 1992, AIDS had claimed the lives of 50 youth between the ages of 13 and 19, and 831 youth ages 20-24, who, because of the eight-to-ten year delay between infection and development of symptoms, probably became HIV-infected while they were teenagers (New York State Department of Health, 1993).

The number of adolescents diagnosed with AIDS continues to grow at an alarming rate. New York City has more reported cases of AIDS among adolescents than any other city in the United States (New York State AIDS Advisory Council, 1991). As of December 1992, there were 89 cases of AIDS among teenagers ages 13-19, and 1,168 cases among young people ages 20-24 (New York State Department of Health, 1993). In New York City, AIDS ranks among the five leading causes of death for children and adolescents, and is now the leading cause of death for young men and women ages 20-39.

Although data on the number of AIDS cases are available because the disease is reportable, there is a large but unknown number of adolescents who are HIV-positive and who will subsequently develop AIDS. Few adolescents infected with HIV develop the symptoms of AIDS until they are in their twenties.

Given the average incubation period of the disease, most of the 6,392 reported cases of AIDS among adults ages 20 to 29 in New York City as of December 1992 were probably infected during adolescence.

Of the cases of AIDS among New York State youth ages 13-24, 42.1 percent of these individuals are homosexual/bisexual males, 31.6 percent are intravenous drug users, 11.5 percent are heterosexual contacts of infected partners, and 3.2 percent fall into other categories. Compared with older age groups, the adolescent/young adult AIDS population, there is a higher proportion of females, blacks, Hispanics, and heterosexual contacts of HIV-infected partners (New York State Department of Health [NYSDOH], 1992). In New York City, the male to female ratio for AIDS cases ages 13-24 is 3:1, but it is 5:1 for individuals over the age of 24 (New York State Advisory Council on AIDS, 1991).

Adolescents at highest risk for HIV infection are, therefore, those who engage in unprotected intercourse, or who share needles with others who are infected. Individuals living in communities with high seroprevalence rates* have a greater risk that sexual partners or those with whom they share needles are infected. High seroprevalence rates in some of the City's communities are sobering. In the South Bronx, for example, estimated seroprevalence rates for males 25 to 44 range from nine to 22 percent (Drucker and Vermund, 1989).

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*In seroprevalence studies, anonymous blood specimens of selected groups are tested for the presence of HIV antibodies, and if positive, confirmed. Seroprevalence rates are the HIV infection rates determined in this manner. These data are used to design and target prevention activities (NYSDOH, 1992).

Studies show that a large proportion of students are sexually active and therefore at risk for HIV infection. According to findings of the Youth Risk Behavior survey conducted by the Centers for Disease Control (CDC) in a sample of 12 New York City public high schools, overall, 56 percent of 769 students reported having sexual intercourse (oral, vaginal or anal).* The percentage increased by grade. Thirty-eight percent of the 74 ninth grade students reported having engaged in sexual intercourse. By their senior year, 67 percent of the 248 high school students had engaged in sexual intercourse; 58 percent of the 126 senior girls and 76 percent of the 122 senior boys had engaged in sexual intercourse.** The proportion of students reporting sexual intercourse differed by race/ethnicity. Overall, sexual activity was reported by 58 percent of the 256 white respondents, 75 percent of the 156 blacks, 56 percent of the 213 Hispanics, and 34 percent of 141 others.

Explosive increases in the rates of sexually transmitted disease (STD) infection among adolescents foretell the frighteningly large proportions of students who can be similarly infected with HIV if the epidemic is not stalled. In 1989, there were 11,000 cases of STDs in adolescents reported in New York City--the highest disease rate of any age group. Even so, the New York City Department of Health considers this figure to be an underestimate due to "underdiagnosis" and underreporting (Hamburg, 1992).

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*The Youth Risk Behavior Survey was conducted in 1991 as part of CDC's Youth Risk Behavior Surveillance System. The school sample was drawn from each of the five boroughs and two of the schools were alternative schools. Special programs were excluded from the sampling frame. A total of 1,003 students in the sample schools completed self-administered survey questionnaires.

**There were 234 observations with missing data for the item asking whether students had ever had any form of sexual intercourse.

Overall, condom use among adolescents is reported to be low and inconsistent. Forty-three percent (N=182) of students responding to a Youth Risk Behavior Survey question reported that either they or their partners used a condom the last time they had sexual intercourse.*

Education continues to be key in the prevention of HIV infection. Schools play a leading role in providing information about the disease and its prevention. According to results of the Youth Risk Behavior Survey, a larger proportion of students learn about HIV/AIDS at school than at home. In 1991, 89 percent of respondents reported that they had been taught about HIV/AIDS in school; in contrast, only 66 percent reported ever talking about HIV/AIDS with their parents or other adults in their family.

Because no cure exists for AIDS and since there is, as yet, no vaccine that can prevent HIV infection, education is the primary means for reducing the spread of HIV. According to the Centers for Disease Control (CDC), school-based programs that teach students about the virus have been effective in reducing sexual practices that place them at risk for HIV infection (1991). However, multifaceted approaches to prevention education must replace traditional didactic instruction. CDC's investigations have determined that factors that increase program effectiveness include: "social skills training, teacher training, use of peer educators, cultural sensitivity, program duration, use of media, and parental, school, and community support for and, involvement in, the program" (CDC, 1991).

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*A total of 752 students responded to this question. Out of these, 330 responded that they "never had sexual intercourse." The percentage of condom users was calculated on the basis of the remaining 422 students.

PROGRAM DESCRIPTION

Expanded HIV/AIDS Education Program/Including Condom Availability

The Chancellor's Expanded HIV/AIDS Education Program/ Including Condom Availability was adopted by the New York City Board of Education on February 27, 1991. The program complies with State regulations and Regents' clarifications. The comprehensive program, for grades kindergarten through twelve, builds on previous AIDS education initiatives in the schools. In the lower grades the Expanded program includes instruction and extensive staff training.* At the secondary school level, the program includes staff development, six HIV/AIDS lessons per grade per year, and a privately-funded, small-grants program (BASE Grants). Condom availability, a program component at the high school level, only, is structured within the context of prevention. Unlike "distribution programs," students are able to obtain condoms only if they specifically request them from specially trained full-time school employees. School staff who are designated to respond to student requests for condoms are instructed to emphasize that the only 100 percent effective way to prevent the sexual spread of HIV and other STDs is to abstain from sexual intercourse and to explain that there are risks to using condoms.

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* A revised curriculum for K-6 was recently approved and as of April 1993, the curriculum has been implemented in some districts.

In a memorandum dated March 26, 1991, Chancellor Fernandez issued implementation guidelines for high schools to establish a broad-based HIV/AIDS Education Team and develop individualized plans for program implementation. The guidelines gave two deadlines for submission of plans (May 1, 1991 and June 3, 1991), in part because some schools were already actively providing HIV/AIDS education (some in partnership with community-based organizations). It was reasoned, therefore, that these schools could be ready to implement the program earlier than others with less experience. Moreover, phased implementation would provide the central administration and those schools in later phases an opportunity to benefit from the experience of schools implementing first. Training for HIV/AIDS Education Teams also occurred in phases. Thirty-nine schools responded by the first deadline, and a committee selected 17 for the first phase of training and implementation. The other schools were assigned to

Phases II and III. (Appendix A contains a list of schools by Phase.)

The New York City Public Schools required members of the HIV/AIDS Education Teams to attend its orientation and training sessions.* The training occurred over three-and-a-half days, and included a half-day Orientation for all Team members, a full day of Tier I Training for the entire team, and two days of Tier II training for faculty and staff who would make condoms available to students. Among the topics covered by the training were basic information about HIV/AIDS, program policies, adolescent development, adolescent sexual behavior including abstinence, community resources and referrals, and condom use and misuse. (The content of the training is described in more detail in Appendix B.) Training for the 16 Phase I schools was centralized. Because of the large number of schools in Phases II and III, however, those trainings were decentralized by superintendency, and special arrangements (e.g. turn-key training) were made for some of the multi-site alternative schools.

In order to receive approval to begin making condoms available, schools were required to demonstrate their readiness to a site visit team from the central administration. Team members observed an HIV/AIDS lesson, visited sites where students would obtain condoms, and assessed the preparations of faculty who would make condoms available. The 17 schools designated as Phase I received permission to commence condom availability between November 1991 and January 1992. The 53 Phase II schools received permission between January and April, and the first of the 51 schools and nine special education programs in Phase III commenced by June 1992. By the end of the 1991-92 school year, all but eight of the Phase III schools that participated in the trainings had made condoms available to students. An additional six special education schools and one new high school were scheduled to begin Phase IV training in October 1992.

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*This training was designed by the HIV/AIDS Training Committee which included New York City Public Schools staff, and representatives of the state and city health departments, unions, advocacy organizations, and community-based organizations.

During the 1991-92 school year, the Office of the Deputy Chancellor for Operations administered the Expanded HIV/AIDS Education Program/Including Condom Availability.* An Internal Working Group consisting of staff with key responsibility for implementation and assessment met regularly to coordinate program activities.**

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*Following a reorganization in 1992, the Division of Student Support Services assumed responsibility for program administration.

**Members of this group include staff of the HIV/AIDS Technical Assistance Project, the Office of the Chief Executive for Instruction, the Office of Health, Physical Education, and School Sports, the Division of High Schools, the Office of Substance Abuse (SPARK), the Office of Parent Involvement, the Office of Research, Evaluation and Assessment, District 75 (Special Education), the Office of the Deputy Chancellor for External Programs and Community Affairs, the Legal Office, the Division of Public Affairs, the Resource Center and Regional Training Center and health coordinators from each of the district superintendent's offices.

Six Comprehensive Health Coordinators (CHCs) in the Office of Health, Physical Education, and School Sports were assigned to the six high school superintendencies to support program implementation. In this role, CHCs established a Borough Health Cabinet in each superintendency to identify and coordinate community-based resources for high schools.*

By design, the Expanded HIV/AIDS Education program receives most of its funding from external sources. Specifically, a Centers for Disease Control grant provides partial support for central office staff responsible for professional development and training, technical assistance, linkages between schools and community-based organizations, and assessment instruments. The HIV/AIDS Technical Assistance Project is funded by a private foundation. Community-based organizations and experts have donated significant amounts of time, particularly in designing and conducting training for HIV/AIDS team members. Condoms were donated by two manufacturers. Participation by school faculty on the teams, including those who make condoms available was strictly voluntary. Foundations and private corporations funded student-initiated BASE (Be Active in Self-Education) grants.

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*There are 120 public high schools and another 25 high school programs serving the 250,000 high school students in the New York City Public School System. A chief executive, who reports to the Chancellor, manages high school matters centrally, but high schools are organized and administered on a borough basis with a high school superintendent for each borough and one for alternative schools and programs. Each superintendent has one staff person assigned as a liaison on health and HIV/AIDS education issues. (New York City Public Schools, 1992)

EVALUATION

The Chancellor has made evaluation an integral part of the HIV/AIDS Education project, both to ensure objective feedback for program planning and policy development and to identify effective strategies for reducing students' risks of HIV infection. Evaluation was designed to occur at the school and overall program levels.

Program guidelines required that evaluation activities be conducted within each school, and that schools submit an evaluation design as part of their HIV/AIDS Education Program expansion plans. (See Appendix C for program implementation guidelines.) OREA provided technical assistance through the development of a series of self-assessment survey questions for staff to use in evaluating their team's efforts at the end of the 1991-92 school year (see Appendix D). OREA also developed and piloted a form for collecting information on utilization of the health resource sites.

The main foci of OREA's evaluation activities during the 1991-92 school year were the HIV/AIDS Team trainings, the implementation of the Expanded HIV/AIDS Education Program, and the program's impact on the school community. More specifically, the objectives of OREA's evaluation during both the 1990-91 and 1991-92 school years were to:

- assess the teacher training conducted during the 1990-91 school year, particularly with respect to the program's goal of integrating AIDS education within a more comprehensive school health program;

- assess the implementation of a peer leadership program in selected schools;
- document the Expanded HIV/AIDS Education program implementation process, particularly in regard to training and resource development;
- provide formative feedback to schools and central school system planners on the extent and quality of implementation;
- determine the impact of the Expanded Program on students, teachers, and other school staff, as well as the school environment;
- identify strategies associated with positive outcomes; and
- recommend changes for strengthening the program.

The Chancellor also encouraged outside evaluation of the program. Accordingly, at a meeting in July 1991, the Chancellor invited respected evaluation specialists to conduct externally-funded research on the Expanded HIV/AIDS Education Program. The purpose of this meeting was to invite objective, external research on short- and long-term outcomes, parent involvement, and community impact. In order to reduce the potential for duplication of effort and encourage the most productive use of resources, OREA was assigned responsibility for coordinating the research and staffing an Evaluation Cabinet composed of the external evaluators.*

Sources of Data

Findings pertaining to the evaluation conducted in 1990-91 are based on observation of five teacher-training sessions conducted during the 1990-91 school year to gain an understanding of the themes covered in these sessions and to assess whether the trainings met the needs of the participants. In addition, during this period, OREA evaluators attended the general training for all peer educators, and conducted site visits to seven high schools and one junior high school with peer leadership programs. Evaluators visited some of these high schools twice--once during the planning stages and again after the program was implemented. They interviewed peer leader advisors at all sites and student peer leaders at most sites. Evaluators also reviewed program materials used during the semester and observed programs developed by peer leader groups in five of the eight schools.

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*As of June 1992, there were seven HIV/AIDS research projects approved by OREA for high schools of which two had obtained outside funding.

The evaluation conducted in 1991-92 gathered new data from three sources: self-administered survey questionnaires completed by participants attending the trainings conducted by the HIV/AIDS Office of Technical Assistance (including, orientation, Tier I, and Tier II trainings); site visit interviews conducted at ten high schools in Phases I and II; and self-assessment reports submitted to OREA by 35 high schools in Phases I-III.

Training evaluations. OREA staff conducted evaluations of the orientation, Tier I, and Tier II training sessions to inform the design of future trainings. Evaluators collected data through anonymous, self-administered survey questionnaires, completed by training participants at the end of each session. Minor adaptations were made in these questionnaires to reflect differences in the training sessions held in each superintendency. OREA staff also observed selected training sessions including each of the orientation sessions, and some of the Tier I and II training sessions. Findings from individual training sessions were reported to the HIV/AIDS Technical Assistance Project's training coordinators.

Site visit interviews. OREA conducted ten site visits to observe how schools implemented the Expanded HIV/AIDS Education Program and to obtain feedback about the program from administrators, staff, students, and parents. The schools in the site visit sample represent diversity on key characteristics. Accordingly, the sample includes schools in Phase I and Phase II from each borough of the city. Seven academic-comprehensive, two vocational-technical, and one alternative schools, all of varying sizes, composed the sample. The schools were chosen to represent the experiences of a broad spectrum of schools in the system but because this is not a stratified random sample, the sample is not representative of New York City public high schools, overall, and findings are not generalizable. Table 1 indicates the characteristics of the sample schools.

The OREA evaluation team also conducted one-day site visits at the ten schools between May 18th and June 8th. In advance of the visits, evaluators asked principals and HIV/AIDS team leaders to arrange for the evaluation team to interview selected categories of individuals (Table 2). OREA requested that respondents represent differing views about the program. The

Table 1

Characteristics of Schools in the Site Visit Sample

Characteristic		Number of Schools
Phase	Phase I	5
	Phase II	5
	Total	10
Borough	Bronx	2
	Brooklyn	3
	Manhattan	2
	Queens	1
	Staten Island	2
	Total	10
Type	Academic-comprehensive	7
	Vocational-technical	2
	Alternative	1
	Total	10
Size	Small (<1,500 students)	2
	Medium (1,500-3,500 students)	7
	Large (>3,500 students)	1
	Total	10

- Half of the schools in the sample were in Phase I and half were in Phase II. At least one school was drawn from each borough and the three main types of schools were represented in the sample. The school populations in sample schools varied from small to large.

Table 2

Number of Respondents Interviewed during Site Visits by Category

Respondent Category	Number
Principal	10
Team Leaders	10
Curriculum Coordinator[a]	10
HIV/AIDS Team Members	71
School staff - Nonteam	18
Students - Team	28
Students - Nonteam	20
Parents - Team	8
Parents - Nonteam	1
Other	1
Total	177

[a] In six schools the team leader also functioned as the curriculum coordinator. In these schools either the evaluators administered the curriculum coordinator's interview after the team leader interview, or the coordinator responded in writing to the interview instrument within several days. In a school with co-team leaders, evaluators interviewed one person as the team leader and the other as the curriculum coordinator.

- The OREA evaluation team conducted 177 interviews during their site visits. Those interviewed included HIV/AIDS education team members (principals, school staff, students, and parents) and individuals who were not members of the teams (school staff, students, and one parent).

team conducted a total of 177 interviews; four of the students and four faculty advisors were interviewed about BASE Grants.*

Self-assessment survey reports. To assist teams in meeting the requirements that they conduct meaningful self-assessment activities, OREA designed an instrument containing questions to help teams identify their accomplishments and plan for program improvements (Appendix D). These questions focused on general issues, the HIV/AIDS education team, the HIV/AIDS curriculum, the health resource room and condom availability, and parent involvement. Questionnaire instructions indicated that schools could respond to any subset of questions they considered relevant to their program. The self-assessment survey was mailed on May 22, 1992 to all high school principals (N=120) and superintendents by the Division of High Schools. Thirty-five schools sent written responses to OREA, including two that were in the site-visit sample. Of the 35 responding schools, six were in Phase I, 16 were in Phase II, and 13 were in Phase III.

SCOPE OF THIS REPORT

Chapter II of this report describes the orientation, Tier I, and Tier II training. Chapter III describes the recruitment and accomplishments of the HIV/AIDS Education teams. Chapter IV addresses issues related to mandated HIV/AIDS instruction and related educational efforts in New York City high schools. Chapter V focuses on the first year of condom availability in Phase I and II high schools, and Chapter VI covers community-based program involvement and resource needs. The peer education program and BASE Grants are discussed in Chapter VII. Evaluators offer recommendations at the end of each chapter. Also included are a glossary of acronyms and terms and appendices containing schools by implementation phase, program implementation guidelines, a self-assessment instrument, curriculum descriptions, and a list of participating community-based organizations.

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*Some of the students and faculty interviewed about the BASE Grants were also interviewed as respondents in other categories.

II. TRAINING

BACKGROUND

The training of school personnel charged with delivering program services to students was central to the implementation of the Expanded HIV/AIDS Education Program/Including Condom Availability. The Chancellor's implementation guidelines required high schools to send their HIV/AIDS team members to special training sessions held during the academic year. This chapter presents a summary of the views of trainees regarding the overall usefulness of the program, the value of particular training activities, the ways to improve future training, the continuing needs for training, and the implications of these opinions. Recommendations on the scope and direction of future training activities are offered at the end of the chapter.

This chapter also includes references to OREA's evaluation of the training segment of the 1990-91 HIV/AIDS Education Project. Although the 1990-91 training sessions were limited to the preparation of classroom teachers to teach the HIV/AIDS curriculum to their students, some of the findings from those sessions are relevant to the discussion in this chapter.*

BACKGROUND OF THE HIV/AIDS TRAINING INITIATIVE

Implementation of the condom availability component of the Expanded HIV/AIDS Education Program required the New York City

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*Among the data sources utilized in the 1990-91 OREA evaluation were survey responses from 550 principals, and information from structured interviews with 14 junior high school and 13 senior high school teachers who participated in HIV/AIDS education efforts in their schools.

Public Schools to develop a training program for staff, students, parents, health care providers, and CBO representatives who had volunteered to serve on the HIV/AIDS team in each high school. The Board's Office of Health hired a training director to oversee the design and implementation of the program, and to coordinate the activities of the HIV/AIDS Training Committee, a group which was made up of representatives from the Board's Division of High Schools and its Office of Health, as well as from eight outside organizations.* The Office of Health also assigned six full-time Comprehensive Health Coordinators (CHCs) to work with each borough's high school superintendency and with the alternative high schools and programs.

Phases of the Training

Each high school, alternative high school, and special education (high-school level) program was required to submit a plan for program implementation prior to being scheduled for training. On the basis of their apparent readiness to implement the program as reflected in their plans, schools were assigned to one of three phases for training:

- Phase I: 16 high schools whose training commenced on June 20, 1991 and was completed on October 29, 1991
- Phase II: 53 high schools whose training commenced on November 19, 1991 and was completed in January of 1992
- Phase III: 51 high schools and 16 special education programs whose training commenced on February 25, 1992 and was completed in April of 1992

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*Outside organizations participating on the HIV/AIDS Training Committee included: the New York State Department of Health; the New York City Department of Health; the AIDS and Adolescents Network; the Upper Manhattan Task Force on AIDS; District Council 37; the United Federation of Teachers; the Council of Supervisors and Administrators; and the American Foundation for AIDS Research.

Components of each Phase of Training

As Figure 1 indicates, the training design was composed of a series of three sessions per phase, for a total of three-and-one-half days of training for the participants. The Orientation was designed to be motivational. The overriding objectives of both the Orientation and Tier I training were to build the HIV/AIDS education teams and provide information on HIV/AIDS. Tier I and II training provided information about program policies, and, the Tier II training (for health resource staff, only) consisted of small group exercises to prepare them for their roles. These three training segments are described in Appendix B.

Scheduling of the Training

Due to their small numbers, it was possible to train individuals from the initial 16 schools and one program together for each training segment under Phase I. With the larger number of schools in Phases II and III, however, it became necessary to hold the Tier I and Tier II training in each borough. The Tier I and Tier II training were managed by the CHCs, in cooperation with their high school superintendent's liaison for health and HIV/AIDS education in each borough.

It should be noted that some team members attended other than their own school's assigned training sessions. This was permitted to accommodate schools' scheduling needs and to ameliorate the hardship of releasing an entire team of staff members from their teaching, counseling, or administrative duties on the same day. Despite this accommodation, however, the length,

Figure 1: Summary of New York City Public High Schools HIV/AIDS Training Program
Academic Year 1991 - 1992

	PHASE I	PHASE II	PHASE III
Number of Schools	16*	53	51 & 16 Special Ed. Programs
Event	Orientation	Orientation	Orientation
Time	4 hours	4 hours	4 hours
Target Audience	HIV/AIDS Team Members Faculty, Staff; Parents, Students	HIV/AIDS Team Members Faculty, Staff; Parents, Students	HIV/AIDS Team Members Faculty, Staff; Parents, Students
Number of People	300	500	500
Date	6/20/91	11/19/91	2/25/92
Location	City-Wide N.Y. Academy of Medicine	City-Wide La Guardia High School	City-Wide La Guardia High School
Objective	Motivation, Information, Team-building	Motivation, Information, Team-building	Motivation, Information, Team-building
Event	Tier I	Tier I	Tier I
Time	1 day (6 hours)	1 day (6 hours)	1 day (6 hours)
Target Audience	HIV/AIDS Team Members Faculty, Staff; Parents, Students (mandatory for Condom Availability Staff)	HIV/AIDS Team Members Faculty, Staff; Parents, Students (mandatory for Condom Availability Staff)	HIV/AIDS Team Members Faculty, Staff; Parents, Students (mandatory for Condom Availability Staff)
Number of People	300	433	500 (est.)
Date	10/10/91	11 - 12/91	3/92
Location	City-Wide	By Superintendency	By Superintendency
Objective	Policy Review, Team-building, Information on HIV	Policy Review, Team-building, Information on HIV	Policy Review, Team-building, Information on HIV
Event	Tier II	Tier II	Tier II
Time	2 days (12 hours)	2 days (12 hours)	2 days (12 hours)
Target Audience	Condom Availability Staff only (NYCPS Faculty & Staff + HIV/AIDS Team Leader or Administrator)	Condom Availability Staff only (NYCPS Faculty & Staff + HIV/AIDS Team Leader or Administrator)	Condom Availability Staff only (NYCPS Faculty & Staff + HIV/AIDS Team Leader or Administrator)
Number of People	140	343	400 (est.)
Date	10/24, 10/29/91	12/91 - 1/92	3 - 4/92
Location	City-Wide J.H.S. 71 (Manhattan)	By Superintendency	By Superintendency
Objective	Skill Building & Information on Adolescent Sexual Behavior including Abstinence, Condom Use & Misuse, Policy Review	Skill Building & Information on Adolescent Sexual Behavior including Abstinence, Condom Use & Misuse, Policy Review	Skill Building & Information on Adolescent Sexual Behavior including Abstinence, Condom Use & Misuse, Policy Review

*In addition, one program was added to Phase I the scheduling, and the location of the training often prevented interested individuals from attending the sessions. This was particularly true in the case of the alternative high schools, where smaller staffs could not be released in any significant numbers without disrupting instruction at their schools.

EVALUATION METHODOLOGY

Data Sources

Data for evaluation of the training were culled from two primary sources. One source was the anonymous, self-administered surveys completed by participants at the conclusion of each training session. These questionnaires elicited feedback on the perceived overall usefulness of the training and the training components, and on additional training and information needs.* The findings reported in this chapter are based only on the completed questionnaires of the survey respondents from the ten schools in the site visit sample.

A second source of data was interview protocols developed by OREA's evaluation team for use during their Spring 1992, site visits to a selected sample of ten Phase I and Phase II high schools.* These interview protocols included questions for HIV/AIDS team staff members concerning their assessments of the training they had attended, their perceptions of the overall usefulness of particular training activities, and their need for future training.

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*OREA issued internal reports on each training session of the three phases to assist the Training Director, the CHCs, and the trainers to identify ways to improve future sessions. OREA evaluators also shared these reports with the borough superintendents to help cabinets plan their own agendas for follow-up technical assistance and training at their high schools.

There are some important differences in the way these two groups of participants were questioned about the same issues. First, the survey respondents, as a group, completed their questionnaires immediately after each session, while their memories were still fresh. Their comments were confined to that particular training, only. Furthermore, their questionnaires furnished "checklists" of response items for them.

In contrast, the site visit interviewees, as a group, were asked to give their "overall" opinions about the training, rather than to comment upon individual sessions. The questions were often open-ended ones, allowing them to answer in their own words. Finally, the interviewees responded to questions based upon their memories of the training(s)--some of which they had attended many months ago.

Description of the Sample

In the survey respondent group, OREA staff compared the number of school staff members from the ten schools who completed surveys after each training session to the total number of staff in attendance from each school (according to attendance lists kept by staff from the Office of Health). Seventy team staff members attended an Orientation session and 19 (27 percent) completed surveys; 92 team staff attended a Tier I training and 38 (41 percent) filled out surveys; and 103 team staff members attended a Tier II training, with 81 (79 percent) completing surveys. As shown in Table 3, the sample includes, predominantly, teachers, guidance counselors, and school administrators.

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*The ten sample schools include seven academic-comprehensive high schools, two vocational-technical high schools, and one alternative high school. See Chapter I for a description of the sample.

The site visit interviewee group was composed of a total of 92 team staff members. This represented 41 percent of the total number of team members (N=222). Of those 92 team staff members, 61 (66 percent) reported attending an Orientation session, 62 (67 percent) reported taking part in a Tier I training, and 63 (68 percent) reported attending a Tier II Training (Table 4). Teachers comprised the largest subgroup of site visit interviewees, followed by guidance counselors, SPARK counselors, and assistant principals.

Overall, almost one-third (70) of the 222 team members from the ten schools in the site visit sample attended an Orientation session. More team members attended Tier I training (41 percent) and Tier II training attracted the highest proportion of trainees, 103 out of 119 health resource staff (87 percent).

On the basis of data from both the site visit interviewee group and the survey respondent group, it appears that all ten

Table 3

Staff Position of Survey Respondents who Attended the Orientation and Tier I Training and Completed Survey Questionnaires[a]

	Orientation (N=70)	Tier I (N=92)
Principal	2	2
Assistant Principal	3	4
Teacher	6	16
Guidance Counselor	3	11
COSA	2	2
SPARK Counselor	1	1
Psychologist	1	0
Social Worker	1	1
Paraprofessional	0	3
Total	19	38

[a] Tier II survey respondents were not asked to indicate their staff position.

- The survey respondent sample is composed predominantly of teachers, guidance counselors, and school administrators from the ten site visit schools. Seventy staff members from the ten schools attended an Orientation, and 19 of them (27 percent) completed questionnaires. Ninety-two staff members from the ten schools attended a Tier I Training, and 38 of them (41 percent) filled out questionnaires.

Table 4

Staff Positions of Interviewees who Reported Attending Orientation, Tier I, and Tier II Training[a]

	N	Orientation	Tier I	Tier II
Principal	10	4	0	0
Assistant Principal	12	6	8	7
Teacher	31	21	21	22
Guidance Counselor	14	12	14	13
COSA	5	4	4	4
SPARK Counselor	11	7	8	10
Psychologist	1	1	1	1
Social Worker	3	1	2	2
Paraprofessional	4	2	3	3
Other	1	1	0	0
Total	92[b]	59	61	62

[a] Interviewees may have attended one or more of the trainings.

[b] Eight of the 92 interviewees reported that they did not attend any of the trainings.

- Eighty-four of the 92 team staff interviewed attended at least one of the trainings. Teachers comprised the largest subgroup of site visit interviewees, followed by guidance counselors, SPARK counselors, and assistant principals.

schools sent a reasonable percentage of team members to each training session, representing a good mix of staff positions. As already discussed, scheduling constraints precluded a larger number of team members from attending these trainings.

PARTICIPANTS' RATINGS OF THE USEFULNESS OF THE TRAINING

Both the survey respondents and the interviewees gave the training positive ratings, overall. Again, the survey respondents rated individual training immediately after the training session, whereas OREA asked interviewees to rate the training, as a whole, in light of their experience with program implementation.

The survey respondents' ratings of the training were more positive than those of the interviewees. When ratings of "very useful" or "somewhat useful" were combined, 89 percent of survey respondents gave the Orientations a positive rating, as did 90 percent for Tier I training, and 70 percent for Tier II (Table 5).

Table 6 indicates how these ratings break down by staff position. The table shows that almost all of the groupings gave the Orientation and Tier I training positive ratings. Some survey respondents who gave the training positive ratings offered the following observations:

- "It was realistic and heart-tugging."
- "It helped me to think of HIV as 'our' disease rather than 'their' disease."
- "Well-planned, thoughtfully presented, serious in tone, substantive in content."

Table 5

Survey Respondents' Rating of Each Training Component

Training Component	Total N	Very or Somewhat Useful N	Very or Somewhat Useful %	Not Very or Not at All Useful N	Not Very or Not at All Useful %
Orientation	19	17	89	2	11
Tier I	38	34	89	4	11
Tier II	81	57	70	24	30

- Survey respondents' ratings of the three training components were strongly positive.

Table 6

Percentage of Survey Respondents Rating Training Segments as Very or Somewhat Useful, by Staff Position[a]

Staff Position	Total N	Orientation N	Orientation %	Total N	Tier I N	Tier I %
Principal	2	1	50	-	-	-
Assistant Principal	3	3	100	4	4	100
COSA	2	2	100	2	2	100
SPARK	1	1	100	1	1	100
Psychologist	1	1	100	-	-	-
Social Worker	1	1	100	1	1	100
Guidance Counselor	3	3	100	11	10	91
Teacher	6	5	83	16	14	88
Para-professional	-	-	-	3	3	100
Total	19	17	89	38	35	92

[a] The evaluation survey for Tier II training did not ask respondents to identify themselves by staff position.

- All categories of staff gave the Orientation and Tier I training positive ratings, overall, with the exception of the two principals, only one of whom gave the Orientation a positive rating.

- "I learned a lot about how extremely emotional this issue of AIDS is and how people deal with their fear of it."
- "It is good to know that there is a support system within the Board of Education for this."
- "Training staff were patient, upbeat, enthusiastic, and informative."
- "I feel that the sessions covered most aspects of our 'job' and that I'll be able to do it. If I can't do it, I now know where to go for help."

Seventy-seven percent of the site visit interviewees gave the training effort an overall positive rating (Table 7). The remaining 23 percent of the interviewees found the training "not very useful" or "not at all useful." There was no significant variation among ratings when respondents' answers were analyzed by staff position (Table 8).

It is interesting to note that the evaluation of the 1990-91 training sessions for teachers of the six mandated HIV/AIDS lessons showed similarly positive findings. Eleven of the 12 teacher attendees interviewed had found the sessions "very helpful." OREA evaluators had also discovered that those teachers with five or fewer years of teaching experience were enthusiastic participants in the training. Despite giving the trainings positive ratings, however, teachers with more than five years of experience thought that they could have implemented the HIV/AIDS curriculum without these training sessions.

Table 7

Site Visit Interviewees' Rating of the Overall Usefulness of the Training
(N=72)

Rating	N	%
Very useful	20	28
Somewhat useful	35	49
Not very useful	11	15
Not at all useful	6	8
Total	72	100

- Seventy-seven percent of the interviewees gave the training a positive rating.

Table 8

Site Visit Interviewees' Rating of the Overall Usefulness of the Training, by Staff Position

Staff Position	Total N	Very or Somewhat Useful N	Very or Somewhat Useful %	Not Very or Not at All Useful N	Not Very or Not at All Useful %
Principal	2	2	100	-	-
Assistant Principal	9	7	78	2	22
COSA	3	2	67	1	33
SPARK	10	8	80	2	20
Psychologist	1	1	100	-	-
Social Worker	2	1	50	1	50
Guidance Counselor	13	10	77	3	23
Teacher	27	22	81	5	19
Paraprofessional	3	3	100	1	100
Other	1	1	100	-	-
Total[a]	71	56	79	15	21

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[a] Position of one staff person was not specified.

- A large percentage training participants in each professional group gave the training a positive rating.

PARTICIPANTS' PERCEPTIONS OF USEFULNESS OF PARTICULAR TRAINING ACTIVITIES

Evaluators asked both interviewees and survey respondents to identify those particular aspects of the training they had found useful. The interviewees were asked this as an open-ended question which referred to any and all of the three training sessions, while the Tier I and Tier II survey respondents were given checklists and asked to rate the specific training activities they had just attended.

Both groups perceived some of the same activities as useful. Among the survey respondents, the training segments identified as most useful in Tier I training were the keynote address and team building activities (each named by 47 percent of respondents) and the program policy updates (37 percent) (Table 9). A large proportion of respondents (79 percent) attending Tier II training for condom availability staff found the condom demonstrations to be useful, as well as the HIV/AIDS informational updates and the training on communicating with teens.

Among the site visit interviewees, the three activities perceived as most useful were the team-building skills segments

(32 percent), the HIV/AIDS informational updates (31 percent), and the condom demonstrations (26 percent) (Table 9).*

PARTICIPANTS' CRITICISMS OF THE TRAINING

OREA evaluators asked the site visit interviewees (in an open-ended question) what training activities were not useful. Fewer than one-third of the 84 interviewees expressed criticism of any one facet of the training. The most frequently expressed criticisms were that the trainings were poorly organized (27 percent), too elementary (22 percent), and imparted too little factual information about HIV/AIDS issues (18 percent). Again, it should be noted that responses of attendees from Phases I and II were pooled. Therefore, the findings do not reflect the results of redesigning the training by the staff after Phase I.

The following are some of the remarks of those site visit interviewees who were unhappy with the trainings:

- "Training were 'top-down' so the planners were not high school personnel. High school personnel know the needs of their students and should have played a major role in the design of this training."
- "Team members' prior training and experience in HIV/AIDS issues should have been taken into account before mandating that they attend all of these sessions."

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*An examination of the 1990-91 findings revealed that these were some of the same activities that last year's respondents had identified as useful. Training attendees at those sessions singled out the trainers' abilities to articulate different strategies for providing HIV/AIDS education to students as particularly helpful. In addition, respondents to the an OREA survey of principals, conducted during the 1990-91 school term, listed the three most popular topics for classroom discussion in their schools as the nature of the HIV virus, the means of its transmission, and the strategies for HIV/AIDS prevention--thereby underscoring the importance of focusing on these topics during teacher training.

Table 9

Aspects of the Training Found Useful by Survey Respondents and Site Visit Interviewees[a]

	Survey Respondents				Interviewees 1991-92 Training (N=84)	
	Tier I (N=38)		Tier II (N=81)			
Aspect	N	%	N	%	N	%
Team Building Skills	18	47	16	20	27	32
HIV/AIDS Information	5	13	33	41	26	31
Condom Demonstrations	NA[b]	NA	64	79	22	26
Communication with Teens	6	16	28	35	17	20
Keynote Address	18	47	NA	NA	12	14
Raising Awareness	8	21	0	0	12	14
Program Policies	14	37	24	30	7	8
Talking to other Teams	NA	NA	NA	NA	13	15
CBO Materials/ Presentations	NA	NA	NA	NA	13	15

[a] Multiple answers were possible.

[b] NA=Not applicable because the segment was not part of the training or because the segment was not one of the fixed response items on the survey.

- Immediately after Tier I training, the segments found most useful were the keynote address and team building. Following Tier II training, participants reported that the condom demonstrations were most useful. With the benefit of program experience, interviewees named the team building and HIV/AIDS information segments as useful.

- "Too much time was spent on sensitivity training, and not enough on medical treatments, transmission risks, statistics, etc."

SUGGESTIONS FOR IMPROVING FUTURE TRAINING

The site visit interviewees were asked (in an open-ended question) to suggest changes that would have made the training more useful to them (Table 10). Twenty-one percent mentioned the inclusion of more factual information on HIV/AIDS issues, 15 percent wanted more training in family counseling techniques, 13 percent suggested more "hands-on" activities and 12 percent thought that there should have been more small group sessions.*

Some of the interviewees had the following to say:

- "Instead of 50-60 percent of the time given to the history, context, importance of HIV/AIDS, they should focus on the daily,'nitty-gritty' of dealing with sexually active teens who don't use condoms and aren't responsive to 'lectures,' 'horror stories,' statistics, etc."
- "Policy issues should come before sensitivity training, since people have a lot of fears about this and discussing policy would allay them."
- "Please make provisions for the periodic reassembly of school-based HIV/AIDS teams for 'sharing' of ideas."
- "More 'nuts and bolts' training should be done on the building level."
- "It is important that the Board of Education look to the school teams for input into future program direction and implementation."

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*Teacher trainees interviewed in the 1990-91 evaluation also remarked that they would have liked more "hands-on" activities during their training.

Table 10

Site Visit Interviewees' Suggestions for Making Trainings More Useful[a]

(N=84)

Suggestion	N	%
Increase HIV/AIDS information	19	21
More on counseling families	13	15
Increase "hands-on" activities	11	13
Include more small group activities	10	12
Program development skills	7	8
Increase CBO activities	6	7
Provide more handouts and lesson plans	5	6
Shorten training	4	5
Include more time for questions and answers	2	2
Provide time to talk to other teams	1	1

[a] Multiple answers were possible.

- Increasing the amount of HIV/AIDS-related information was the most frequently voiced suggestion by team staff for improving the training.

ONGOING TRAINING NEEDS

Both the site visit interviewees and the survey respondents described their needs for additional training.* As presented in Table 11, 42 percent of the Orientation survey respondents asked for additional training in increasing program support and in counseling HIV-positive students and their families. The Tier I respondents wanted more training in securing program materials (21 percent), and more informational updates on HIV//AIDS issues (16 percent).** The Tier II training survey respondents, who were all health resource staff, wanted additional "tips" on increasing program support (78 percent), more training in the area of adolescent development (35 percent), and ideas on promoting multiculturalism (30 percent). It is likely that the higher percentage of requests for additional training from the Tier II health resource staff reflected their growing awareness of how much more they needed to know as their levels of sophistication in HIV/AIDS training issues increased.

The site visit interviewees had already implemented their programs by the time the OREA evaluators arrived in their schools. In their responses to ongoing training needs (Table 12), they expressed the need for continuing HIV/AIDS informational updates (57 percent), additional training in the counseling of HIV-positive students and their families (21

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*The interviewees were asked this as an open-ended question, while the survey respondents chose from a checklist.

**Similarly, the majority of the 1990-91 training interviewees had expressed a desire for regular HIV/AIDS updates.

Table 11

Additional Training Needs of Survey Respondents by Training Segment[a]

Training Need	Orientation (N=19)		Tier I (N=38)		Tier II (N=81)	
	N	%	N	%	N	%
Adolescent development	3	16	1	3	28	35
Gay and lesbian youth	4	21	-	-	17	21
Curriculum issues	4	21	2	5	1	1
Program implementation	-	-	2	5	1	1
Program policies	3	16	2	5	14	17
Increasing program support	8	42	1	3	63	78
Communication skills	-	-	-	-	14	17
Multicultural issues	5	26	-	-	24	30
CBO resources	5	26	5	13	18	22
How to reduce the risk of HIV infection	5	26	-	-	1	1
Counseling HIV-positive students and families	8	42	3	8	1	1
HIV/AIDS updates	1	5	6	16	1	1
Condom availability issues	-	-	4	11	9	11
Materials/lessons/videos	-	-	8	21	1	1
Peer leadership	3	16	-	-	1	1
Substance abuse issues	2	10	-	-	8	10

[a] Multiple answers were possible.

- Two-fifths of the Orientation respondents wanted training in increasing programs support and counseling HIV-positive students and their families. One-fifth of the Tier I respondents requested more materials, lessons, and/or videos. Approximately three-fourths of the Tier II respondents wanted training on increasing support for the program and about one-third desired more training on adolescent development.

percent), and more "tips" on ways to increase support for their programs (19 percent).

Finally, though these trainings did not focus on the teaching of the six mandated HIV/AIDS lessons, several respondents addressed this issue, which is covered, in depth, in Chapter IV. Their remarks indicated that some individuals assigned to teach the lessons were still nervous about teaching the material and needed more support. Some participants suggested that the school-based HIV/AIDS teams become directly involved in the training of their own teachers, thereby decentralizing that part of the program's training initiative. This, they argued, would make the training more responsive to each school's needs and more reflective of each school's culture. Other respondents urged that the central administration designate "master teachers," either within or among neighboring high schools, who could model variations of the six mandated HIV/AIDS lessons for the experienced teachers, and fully train the new ones. These comments mirrored the concerns of last year's teacher trainees, who had asked for revised lesson plans and had requested additional assistance in identifying, locating, and obtaining up-to-date HIV/AIDS educational materials.

The following is a sample of the comments regarding ongoing training needs of HIV/AIDS education teachers:

- "We need training in long-range planning, such as what to do when your faculty changes and you need to train new team members, or when your condom volunteers 'burn out' and you need to recruit new ones."
- "My main concern is where do I draw the line between becoming emotionally involved with the students and their families, and letting this interfere with my home life."

Table 12

Additional Training Needs Identified by Site Visit Interviewees[a]
(N=53)

Training Need	N	%
HIV/AIDS updates	30	57
Counseling HIV-positive students and families	11	21
Increasing program support	10	19
Curriculum issues	5	9
Training new team members	5	9
Communication skills	4	8
Materials/lessons/videos	3	6
CBO resources	3	6
Program policy updates	2	4
Sharing with other teams	2	4
Adolescent development	1	2
Program implementation	1	2
Multicultural issues	1	2

[a] Multiple responses were possible.

- More than one-half of the interviewees wanted ongoing HIV/AIDS informational updates and about one-fifth wanted more training in counseling HIV-positive students and their families. Another 19 percent wanted "tips" for increasing program support.

- "Because the information on AIDS is constantly changing, this will always bring about questions for which my information may be outdated, which makes me uncomfortable."
- "We need to be told more about arts resources, such as plays, musical presentations, lyrics, videos by and about teens, etc."
- "Teams need the opportunity to express concerns that could impact upon the long-term success of our programs."

CONCLUSIONS AND RECOMMENDATIONS

The training of the HIV/AIDS team members from the 120 New York City public high schools and programs was completed during the 1991-92 academic year.* By their own reports, approximately two-thirds of the 92 site visit interviewees attended at least one training session. This was not so among the survey respondents, whose attendance increased as the training progressed as follows: Orientation, 32 percent; Tier I, 41 percent, and Tier II, 87 percent. The breakdown of participants by staff position was similar for the two samples, however, with teachers comprising the largest sub-group, guidance counselors the second largest, and Assistant Principals the third.

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*As was noted in the introductory section of this chapter, the location and the scheduling of the training prevented some interested school staff members from attending. In addition, new team members and condom volunteers were in need of training before they assumed their duties for the 1992-93 school year. To address the needs of both of these groups, the Director of Training and her staff scheduled a new training segment--Phase IV--to commence in early October 1992, and run through early November 1992. Announcements and registration forms were sent to all New York City public high schools and special education programs to give each school the opportunity to send staff to these sessions. To assist in planning future training, the office enclosed a form with each announcement that requested schools to identify additional HIV/AIDS training needs for the upcoming academic year.

Both the site visit interviewees and the survey respondents gave the training positive ratings, overall. Among the interviewees, 77 percent of them found the training "very useful" or "somewhat useful." The survey respondents showed even more enthusiasm, with between 70 percent and 90 percent of them finding each of the three segments "very useful" or "somewhat useful."

When asked which training activities they found particularly useful, both the interviewees and the survey respondents named some of the same workshops. Thirty-two percent of the interviewees and 47 percent of the Tier I survey respondents found the team building activities useful. Thirty-one percent of the interviewees and 41 percent of the Tier II survey respondents found the HIV/AIDS updates useful. Finally, 26 percent of the interviewees and 77 percent of the Tier II survey respondents found the condom demonstrations useful. In addition, between 30 percent and 37 percent of the survey respondents found the program policy updates useful.

OREA evaluators asked only the interviewees to indicate what training activities they had not found useful. The chief criticism of the 84 respondents was that the sessions could have been organized more effectively (27 percent). Twenty-two percent of the interviewees said that the training included too much elementary information for team staff--some of whom already had extensive experience in HIV/AIDS education. Other criticisms voiced by trainees were that the sessions imparted too little factual information on HIV/AIDS issues, and that some of the facilitators showed an insensitivity to the concerns of the group.

Evaluators also asked site visit interviewees what aspects of the trainings could be made more useful to them. The most frequent suggestion (21 percent) concerned having more factual information on HIV/AIDS included in the sessions. Fifteen percent of the interviewees expressed a need for additional training in family counseling techniques, and approximately 12 percent of them remarked that sessions should have made more generous use of small group and "hands-on" activities.

Both groups of participants were asked to identify their ongoing training needs, and both expressed similar concerns. Fifty-seven percent of the interviewees and 16 percent of the Tier I survey respondents would like continuing updates on HIV/AIDS issues. Twenty-one percent of the interviewees and 42 percent of the Orientation survey respondents asked for more training in the counseling of HIV-positive students and their families. Nineteen percent of the interviewees, 42 percent of the Orientation survey respondents, and 78 percent of the Tier II survey respondents wanted additional advice on how to increase support for their HIV/AIDS programs. Thirty-five percent of the Tier II survey respondents also desired more training in adolescent development, and 30 percent of them said they needed to be better sensitized to multicultural issues.

OREA evaluators offer the following general recommendations regarding the conduct of future training activities for team members and other interested staff, students, and parents during the 1992-93 school year:

- Empower schools to play a larger role by increasing team involvement in the design and execution of future training events. To address the need for updates on medical and policy issues, teams should also be encouraged to organize staff development activities in their own schools. Moreover, this might be one way to build program support.

- As part of Tier I and Tier II training, conduct workshops or other activities designed for the more advanced participants who already possess solid backgrounds in the areas of HIV/AIDS and adolescent health.

- Consider holding shorter, more frequent training events and make them more focused and intensive.

- Develop better methods to keep team members informed about continuing HIV/AIDS-related developments. Some suggestions include publishing a monthly HIV/AIDS newsletter, developing an accessible computerized database of HIV/AIDS articles, and initiating an HIV/AIDS E-mail "hotline" to handle team members' questions.

III. HIV/AIDS EDUCATION TEAMS

This chapter describes the structure and functioning of the HIV/AIDS Education Teams. Team activities related to the HIV/AIDS lessons are discussed in Chapter IV and activities related to condom availability are discussed in Chapter V of this report.

Findings in this chapter are based on interviews conducted during site visits to a sample of 10 high schools and on self-assessment reports submitted to OREA by 35 high schools (in Phases I-III).

BACKGROUND

The guidelines for the Expanded HIV/AIDS Education Program required that every high school form an HIV/AIDS Education Team or expand an existing team for this purpose. Mandated team composition included, at minimum, the principal, an assistant principal, one teacher, one student, one parent, and health resource staff. It was strongly recommended that each team consist of more than one teacher, student, and parent. Guidelines also suggested that team membership be extended to others in the school including guidance counselors, social workers, SPARK counselors, special education staff, school-based health clinic personnel, and paraprofessionals. Participation on the team and in team-related activities was to be voluntary. By encouraging the establishment of a broadly-based team and promoting the expansion of HIV/AIDS education beyond the purview of health education classes to other academic subject classes (see Chapter IV), the Expanded Program was designed to mobilize the resources of the school community to address this serious epidemic.

Each team's responsibility was to plan and facilitate HIV/AIDS education in the school and to implement the condom availability component of the program. As its first task, the team developed a statement of purpose and an annual plan. Follow-up activities included: identifying teachers for the mandated lessons, recruiting outside agencies into the school's program, defining and enforcing a policy to protect the privacy of students obtaining condoms, and creating a calendar of HIV/AIDS education activities for the school year. In addition, teams designed internal assessment procedures for the program and identified school-based counseling resources and community referral sources.

Comprehensive health coordinators provided teams with written materials either targeted to staff or students including Karen Hein's book, *Trading Facts for Fears*, and encouraged team members to contact the HIV/AIDS Resource Center in one of the alternative schools. In addition, the Technical Assistance Project provided a list of sources for publications and materials. Technical assistance staff also responded to information and materials requests from individual schools.

TEAM STRUCTURE

Recruitment and Composition

All 10 of the principals interviewed by OREA reported making an effort to recruit team members who represented a cross-section of the school community and possessed expertise in HIV/AIDS or adolescent health issues. As shown in Table 13, assistant principals comprised approximately half of all team leaders. Team leaders at other schools included a work-study coordinator, health and physical education teachers, and a guidance counselor. At one school, a parent with professional expertise in HIV/AIDS education served as team leader.

Principals and team leaders solicited members through announcements at staff meetings, by memo, or in person. All of the team members interviewed by OREA confirmed that they had volunteered to participate in the program. Asked why they volunteered, staff expressed concern for their students and a desire to do something to halt the spread of the HIV virus. Several team members said their involvement was natural since they taught health or science. Representative responses included the following:

- "I was concerned about the AIDS epidemic and I saw this as an opportunity to educate students about it."
- "I know there are many kids who are sexually active and I think this is a disease we can prevent through education."
- "HIV is such a crisis and I wanted to be involved in trying to prevent it as much as possible."
- "I felt comfortable talking about AIDS and thought students would feel more comfortable with a younger teacher."

Table 13

Positions of Team Leaders, Team Size, and Percentage of Team who were Health Resource Staff

School	Team Leader	Team Members N	Health Resource Staff N	Health Resource Staff %
1	Work-study Coordinator	32	10	31
2	AP Science and Math	10	7	70
3	AP Health and PE	18	10	56
4	HIV/AIDS Education Coordinator	30	30	100
5	AP Social Studies	15	7	47
6	Health and PE teacher	14	3	21
7	Guidance Counselor/Health & PE Coordinator[a]	40	24	60
8	AP Guidance	16	10	62
9	Parent	30	10	33
10	AP Health and PE	17	8	47
Total		222	119	54

[a] This school had co-team leaders.

- Approximately half of the HIV/AIDS team leaders were assistant principals. Teams ranged in size from 10 to 40 members. Health resource staff comprised from 21 to 100 percent of the team.

Seventy-four percent (N=17) of the 23 self-assessment reports addressing this issue, indicated that their team reflected their student population's racial, ethnic, and gender composition. Twenty-six percent (N=5) reported that their team did not entirely represent the composition of their schools but did not think that this compromised teams' effectiveness.

Several principals reported an underrepresentation of parents on their HIV/AIDS teams. Daytime meetings created attendance difficulties for working parents, as did the distances between school and home or work, and the typically low levels of school involvement for parents of high school students. One team leader commented, "...the issue of parent involvement in HIV/AIDS education is the same as parent involvement in general. There is always a small (10 percent) active group with whom communication is ongoing and who are supportive of programs which they understand to be necessary and then there is the rest." In some schools, teams sought to increase parent participation through parent associations.

A few principals commented that more Limited English Proficient (LEP) program staff needed to be included on HIV/AIDS teams to better serve this student population. One school visited by OREA addressed this problem by adding a bilingual guidance counselor to the team.

Size

Although implementation guidelines established a minimum of six members on the HIV/AIDS Education Teams, the teams in the site visit sample ranged in size from 10 to 40 members (see Table 13). Six teams had fewer than 20 members, and four teams had 30 or more. The proportion of team members who were also health resource staff ranged from 21 to 100 percent.

Changes in Team Composition

All 10 team leaders interviewed by OREA indicated that their teams had experienced membership changes during the 1991-92 school year. Most grew in size, with seven of the 10 team leaders adding new members to the team. At one school the team grew from six to 30 members. Three of the team leaders reported that some members dropped out; at two schools this was because of other commitments and time constraints, and at the other school some members were opposed to the program for religious reasons.

TEAM FUNCTIONING

Overall Functioning of the Teams

All ten principals rated the overall functioning of their teams as "excellent," and attributed this primarily to the commitment of the team members. One principal said, "Our team is composed of very sensitive people who are interested in all aspects of youngsters' growth, take the task seriously, and realize that there is an educational component involved in making condoms available." As an illustration of staff commitment, another principal related that in an effort to improve access, team members stayed after school to make condoms available to students.

Team Meetings

Most of the teams (69 percent) met during regularly scheduled times at least once a month or more, and thought that this frequency was sufficient to accomplish their objectives (Table 14). Those who said they met "as needed" explained that the frequency of team meetings depended upon the demands of the activities they were undertaking. Team leaders said that flexible schedules encouraged meaningful participation at meetings when they were held.

Several team leaders and members reported that their teams faced difficulties arranging a convenient time to meet. Since participation on the team was voluntary, teams met on their own time, either before or after school or during lunch hours. One staff member remarked that the team accomplished much of its work in hurried individual meetings between the team leader and a team member. The one alternative high school in the site visit sample having multiple sites, had a particularly difficult time arranging team meetings since its staff was rarely in the same place at one time. The team addressed this problem by meeting informally in small groups and more formally during regularly scheduled faculty meetings.

Team Assessments of Their Own Accomplishments

Team members expressed satisfaction with their teams' accomplishments. The majority of team members reported that, in their opinion, students were becoming more aware of HIV

Table 14

Frequency of Team Meetings as Indicated in Self-Assessment Reports
(N=32)

Meeting Frequency	N	%
More than once a month	6	19
At least once a month	16	50
As needed	6	19
Four times during the year	2	6
No formal meetings	2	6
Total	32	100

- Sixty-nine percent of the teams met once a month or more, 19 percent met as needed, and 12 percent met only four times during the year or held no formal meetings.

prevention issues and the importance of using condoms if they were sexually active. In addition, several thought they had increased staff awareness of the need for this program, and heightened student and faculty sensitivity about people with AIDS. At five of the ten schools in the site visit sample, team members explicitly identified the successful implementation of the condom availability program as their major accomplishment this year. (The condom availability program component is described in Chapter V of this report.)

Factors that Facilitated and Impeded Team Functioning

In general, team members--staff, students, and parents--expressed enthusiasm about their involvement in the program. Staff cited dedication, commitment, and a common belief in the program among participants as major reasons for its success. Other team members singled out "motivated leadership" from team leaders, support from the school administration, and group rapport in enhancing the teams' work.

Several team members said that time constraints and, especially the lack of release time for HIV team meetings contributed to obstacles in program implementation. Others mentioned that their team needed more materials in the resource rooms and updated pamphlets and brochures to distribute to students.

HIV/AIDS Education Team Activities

The teams planned and implemented the HIV/AIDS instructional program, student activities, condom availability, and parent education. Table 15 shows the range of activities conducted by teams as noted in the self-assessment reports from schools in Phases I-III. It should be noted that because team members responded to open-ended questions in these self-assessment reports, the list may not include certain activities that respondents participated in earlier in the school year but had forgotten by the time they prepared the report. This is evident in the small number (N=3) of schools reporting coordination of HIV/AIDS education, an activity conducted by all of the teams.

Other activities reported by team members during site visits included: arranging for guest speakers and theater groups, conducting peer leadership programs, overseeing the BASE (Be Active in Self Education) grants, and organizing "rap" groups and role playing exercises. Staff believed that, on the whole, these activities were highly successful in increasing student awareness about HIV/AIDS issues.

Parent Information Sessions

Parents on the HIV/AIDS Education Teams served as liaisons to other parents, both representing parents' perspectives during team meetings and providing ongoing feedback to other parents through the parent associations.

The Expanded HIV/AIDS Education Program mandated that informational sessions be held for parents in each participating school (Mandate 9). In these sessions, team members taught parents about HIV infection and AIDS, explained the Expanded

Table 15

Team Activities Identified in Self-Assessment Reports[a]
(N=29)

Activity	N	%
Counseling and referrals	8	28
Meetings and organizational activities	6	21
Condom availability	4	14
AIDS awareness week	4	14
Health fair	3	10
Supervised student-made posters/ pamphlets/murals	3	10
Coordinated HIV/AIDS education	3	10
Small group sessions	3	10
Peer leadership training	3	10
Classroom presentations	2	7
Program evaluation	2	7
Role playing	1	3
Participating in community meetings	1	3

[a] Multiple answers were possible.

Note: Respondents may have underreported activities because they did not recall those occurring early in the school year or because they thought that the question called for reporting other than mandated activities.

- The teams planned and conducted a wide range of HIV/AIDS awareness activities for students in addition to their responsibilities for HIV/AIDs instruction and implementing the condom availability program.

HIV/AIDS Education Program, and described the HIV/AIDS lessons. Team members addressed parents' questions and concerns at the end of their presentations. Nine team leaders reported that their schools held such information sessions. Parents' attendance at these meetings ranged from 25 at one school to 350 at another. According to the team leader from the alternative school where the information session was not held: "Parents aren't that involved since students range in age from 18 to 21."

Seven of the ten schools conducted information sessions as part of parent association meetings. One school held two meetings--one on the condom availability component of the program and another to help parents talk to their children about sex. Another school invited guest speakers to assist at their parent workshop.

In three schools, the parent association organized the session and in one school the session was co-sponsored by the parent association and a local hospital. Another school had its session conducted by the administration's consultative council, and a third by the Coordinator of Student Activities (COSA). The other three team leaders did not specify who organized their meetings. All of the information meetings were held on school grounds in the evening or on the weekend.

PERCEPTIONS OF PROGRAM OUTCOMES

Students' Perceptions*

To assess student opinions about the outcomes of the HIV/AIDS Education Program, OREA evaluators asked students if they thought the HIV/AIDS Program influenced selected student behaviors -- talking about using condoms, using condoms, getting counseling, and talking to an adult in school about problems. In the analysis, OREA distinguished between students on their school's HIV/AIDS Education Team (N=28) and those who were not team members (N=20) (Table 16). The more positive responses of the team members may be a result of their participation on the team and/or the characteristics that predisposed their joining the team. It should also be noted that the sample is in no way representative of students in these schools, since principals selected respondents who represented a diversity of opinions about the program. Moreover, findings should be considered preliminary because of the small number of students and the uncertain reliability of these interview questions.

Fifty-seven percent (N=27) of students thought that the program had helped increase communication among students about condom use while 36 percent (N=17) said that the program had no effect in this area. Sixty-seven percent of team members versus 45 of non-team members said that students were more likely to

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*Team leaders' perceptions of the impact of the program are discussed in Chapter V.

Table 16

Percentage of Students Reporting Changes in Students' Behaviors as a Result of their Schools' HIV/AIDS Education Program Activities

	Team Students (N=28)				Nonteam (N=20)			
	(N)	Less %	Same %	More %	(N)	Less %	Same %	More %
How often they talk to each other about using condoms	(27)	3	30	67	(20)	10	45	45
How likely to wait until they are older to have sexual intercourse	(24)	17	50	33	(18)	17	44	39
How often they use condoms	(26)	0	8	92	(18)	17	5	78
How likely they are to get HIV/AIDS counseling or testing	(24)	8	21	71	(18)	33	22	44
How likely they are to talk to an adult in their school about problems	(26)	8	27	65	(18)	17	33	50

- Most of the students interviewed thought that the HIV/AIDS program Including Condom Availability was having an impact on other students in the school particularly in terms of increasing the likelihood that they would, get HIV/AIDS counseling or testing, talk to an adult about their problems, and use condoms.

talk with each other about using condoms as a result of the HIV/AIDS Education program.

An overwhelming majority, 86 percent, of students (N=38) thought that students used condoms more often as a result of the program although, again, a larger proportion of team students thought that more students were using condoms than nonteam students (92 percent and 78 percent, respectively). Thirty-six percent (n=15) thought that students would be more likely to wait until they were older to engage in sexual intercourse with similar proportions of team and non-team students voicing this opinion.

Several HIV/AIDS Education Program administrators hypothesized that because schools had identified caring adults who were willing and able to talk openly to students about teen sexuality and health issues, students had become more open about discussing personal problems with these staff members. OREA interviewers asked students two questions to address this issue. The first was whether students were more likely to get counseling or testing as a result of the program. Almost twice as many team students (71 percent) as nonteam students (44 percent) thought students were more likely to be counseled or tested as a result of the program. The second question focused on communication between students and staff. Like administrative staff, the students believed that communication had increased as a result of the program. A majority (59 percent) of students (N=26) said that students were more likely to talk to an adult in the school about problems. A higher proportion of team students (65 percent) than nonteam students (50 percent) said that students were more likely to talk to an adult in their school about problems as a result of the program.

CONCLUSIONS AND RECOMMENDATIONS

All of the schools established HIV/AIDS Education Teams broadly representative of the academic disciplines and support services, and of their student populations. OREA found, through site visits and self-assessment reports, that most schools developed teams that were effectively carrying out the program mandates.

Team members interviewed expressed a strong commitment to the program and pride in its accomplishments. According to staff, dedication and commitment of the team members, team leaders' "motivated" leadership, support from the school administration, and group rapport all helped enhance team performance. Evaluators found, however, that lack of sufficient release time for HIV/AIDS team meetings as well as time constraints in general, served as obstacles to program planning. In addition, some team members felt hampered by the lack of updated materials for students and limited parental involvement on HIV/AIDS teams was a problem for the program overall.

For most of the schools, developing the teams and responsibly implementing the condom availability component consumed most of their efforts in the 1991-92 school year. Compliance with the mandate to teach six HIV/AIDS lessons in each grade was also a priority, although the time involved in building the teams seems to have diverted attention from the instructional curriculum (see Chapter IV).

Teams conducted a wide range of activities to increase student awareness about HIV and AIDS. These included inviting in outside speakers and performers, conducting workshops, working with students on posters and displays, facilitating peer education groups, and organizing and conducting HIV/AIDS awareness days and health fairs.

OREA evaluators asked students their opinions about the impact of the program on other students in their schools. Findings should be considered preliminary and tentative only, due to concerns about the small number of respondents and the uncertain reliability of these interview questions. Most students thought the HIV/AIDS Education Program was having a positive impact in three areas: increasing the likelihood that students would get HIV counseling or testing; opening up communication between students and adults in the school about students' problems, and increasing the use of condoms among sexually active students. Overall, student members of the HIV/AIDS teams thought that the impact of the program was more positive than students who were not team members.

With respect to the HIV/AIDS Education Teams, OREA offers the following recommendations:

- Ensure that there is immediate information for principals and team leaders whenever an important HIV/AIDS policy change is imminent.
- Give more recognition to team members who are volunteering for the program without release time. Suggestions for formally recognizing team members' contributions include: special luncheons or dinners, staff retreats, or assisting them in becoming certified HIV/AIDS educators. Acknowledge the commitment of volunteers on the HIV/AIDS education teams to reinforce their continued participation in the program.

- To overcome one of the obstacles to parent involvement, teams may want to consider holding some meetings early in the morning, in the late afternoon, or in the early evening.

- Help schools obtain updated publications, videos, and resources, including bilingual materials. Schools reported needing assistance in both identifying and obtaining appropriate publications, and purchasing them directly.

IV. IMPLEMENTATION OF THE HIV/AIDS CURRICULUM

BACKGROUND

In 1986 the New York City Public School system began implementing HIV/AIDS education through the Office of Health, Physical Education and School Sports (OHPESS). Initially, the project mandated two HIV education lessons per year for junior and senior high school students. In 1987, OHPESS received increased funding from the federal Centers for Disease Control to expand the program to six lessons per grade per year. However, monitoring visits in 1990-91 had identified many schools failing to provide the required instruction. The Chancellor's Expanded HIV/AIDS Education program made these six lessons mandatory. Administrative responsibility for the HIV/AIDS curriculum was transferred from OHPESS to the newly established HIV/AIDS Technical Assistance Project office for the 1991-92 school year. To underscore the far-reaching impact of the HIV/AIDS epidemic and to involve much of the school community in HIV/AIDS education efforts, the program's founders sought to extend HIV/AIDS instruction beyond health education classes to academic subject classes such as science, social studies, English, and math. Accordingly, the Chancellor's guidelines recommended that schools integrate the subject of HIV/AIDS into as many academic subject areas as possible.

As part of their plan for implementing the Expanded HIV/AIDS Education Program, school officials were required to submit plans to central headquarters describing how the six lessons would be taught at their schools. Although all schools reported implementing the six lessons, new teacher training was minimal because of the 1991-92 focus on school team building and implementing the condom availability plan.*

OREA used several data sources for its assessment of curriculum implementation in the 1991-92 school year. Evaluators interviewed curriculum coordinators in each of the ten site visit sample schools. In six out of the 10 schools, that coordinator also served as HIV/AIDS team leader. OREA asked team and non-team students and staff for their assessment of the HIV curriculum and of the overall educational efforts at their schools. Finally, self-assessment reports from 35 schools (in Phases I-III) provided additional sources of information about the curriculum.**

CURRICULUM IMPLEMENTATION/EFFECTIVENESS

All ten schools visited implemented the six lesson mandate. Curriculum coordinators in seven of the ten schools in the site visit sample reported using the AIDS Supplement to Family Living published in 1989 as their primary curriculum (Appendix E).* Lesson 1 (What is AIDS?) and Lesson 2 (How can we deal with fears about AIDS?) were developed for all secondary grade levels while Lessons 3 through 6, although similar in theme, had different instructional plans designed for each grade. Lesson 3 focused on how HIV infects the body, Lesson 4 addresses what families and the community can do to help people with AIDS, Lesson 5 covers what each person can do to prevent the spread of HIV infection,** and Lesson 6 addresses civil liberties issues related to HIV/AIDS. The goal was for each of these themes to be addressed with increasing sophistication and depth in each succeeding grade.

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*HIV/AIDS Technical Assistance Project staff reported that 67 teachers and 20 department chairs received instructional training. Staff noted that increased teacher training will be a priority in the 1992-93 school year.

**OREA did not conduct classroom observations during the 1991-92 school year.

Coordinators expressed mostly positive feelings about the quality of the HIV/AIDS curriculum, but virtually all staff members interviewed said that they did not strictly adhere to the curriculum and that it was used more often as "a jumping off point." Four of the ten coordinators reported supplementing these lessons with teaching ideas culled from the New York State Education AIDS Instructional Guide. The coordinator at one school commented that she mixed the AIDS Supplement to Family Living with State Education recommendations to achieve maximum effectiveness. In addition, half of the schools used lessons from the five-session SPARK HIV/AIDS Education Supplement (Appendix F) to satisfy the six-lesson mandate as well as to provide additional instruction. Other teachers developed their own HIV/AIDS lessons, sometimes combining them with materials from state and city sources. As the team leader at one school noted: "It [the HIV curriculum] is a good beginning point. But we need to embellish it with material relevant to our own population."

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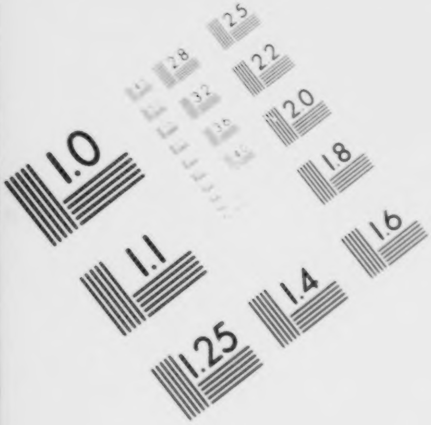
* The AIDS Supplement to the Family Living and Sex Education Curriculum is scheduled to be updated in 1993.

**Parents were permitted to opt their children out of the HIV prevention lessons.

Three coordinators praised the curriculum as "excellent," with one interviewee remarking that it was "comprehensive and addressed all relevant issues while stimulating thought and discussion." Three other staff expressed some criticism of the curriculum, however, with one teacher describing it as "outdated" because of insufficient information on risks associated with specific kinds of sexual behaviors and insufficient mention of AIDS cases as they related to females. Another curriculum coordinator commented that the Supplement to Family Living needed more lessons geared to a younger age group.

Teachers within the same school sometimes expressed very different opinions about the curriculum. At one school, comments from four different staff members ranged from "very good, kids learned a lot" and "kids respond to it well" to "limited value" and "very poor because it isn't relevant to the Chinese population."

The majority of staff opinions about the curriculum were positive, with some qualifications. A typical comment was: "It's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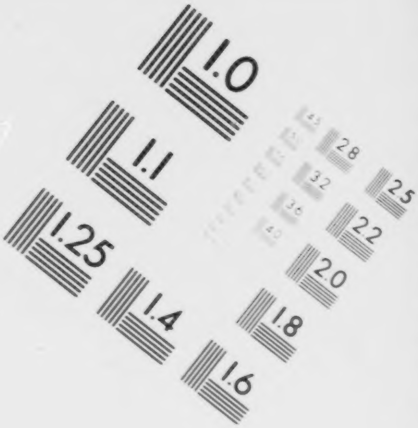
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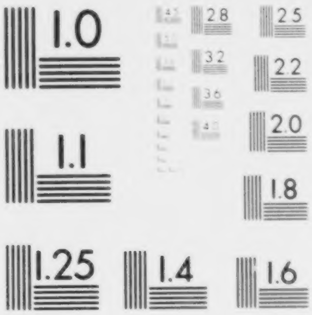
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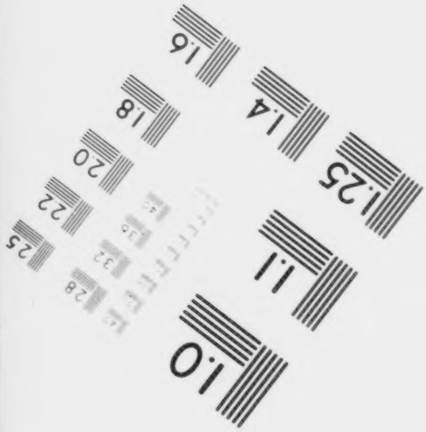
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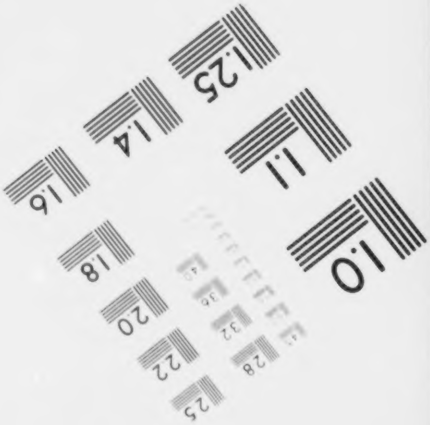
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a good start but we need to integrate more ideas into the lessons" and "...[it] has been very effective, but we have to keep the activities going; otherwise it isn't worthwhile." At one school, an HIV/AIDS education team member commented that "teachers are generally resistant to any curriculum that comes from the Board."

INTEGRATING THE HIV/AIDS CURRICULUM IN ACADEMIC SUBJECT CLASSES

The ten schools varied substantially as to how they chose to implement the curriculum. In eight of the schools, the HIV/AIDS curriculum was taught, at least partially, in regular academic subject classes other than health. Six of the eight reported teaching it in social studies classes, six in science classes, and five in English classes (Table 17). In addition, SPARK prevention specialists in five of the schools visited conducted their own HIV lessons to satisfy the six lesson requirement.

Although HIV/AIDS lessons were presented in academic subject classes other than health, this did not always mean that academic subject teachers provided the instruction. At one school, HIV/AIDS education was taught only by health and physical education instructors and in several others either health teachers or SPARK intervention staff came into regular academic subject classes to teach HIV/AIDS lessons. In other schools visited, non-health academic subject area teachers taught at least some of the lessons but OREA evaluators could not always determine how frequently these staff provided instruction and how often SPARK or health teachers assisted. It is likely that the reason

Table 17

Academic Classes in which HIV/AIDS Lessons were Taught, by School

School	Health	PE	Science	Social Studies	English	Math	Other
1	■	■	■	■	■		
2	■	■	■	■	■		
3	■		■	■	■		■
4[a]							
5	■		■	■	■	■	
6	■	■	■	■	■		
7	■	■	■	■			■
8	■	■					
9			■	■	■		
10	■	■	■	■	■		
Total	8	6	8	8	7	1	2

[a] In this alternative school, HIV/AIDS lessons were taught at work sites during the regular instructional portion of the day. The HIV/AIDS lessons were usually combined into three sessions of two lessons each although other schedules were used at different work sites.

- HIV/AIDS lessons were taught in academic classes as well as health and physical education (PE) classes. In eight of the ten schools in the site visit sample, HIV/AIDS lessons were taught in Science and Social Studies and lessons were taught in English classes in seven schools.

health teachers in many schools was because these instructors had the most training and background in the field. OREA evaluators observed, however, that several schools visited were makingHIV/AIDS education became the province of SPARK specialists andsignificant progress in training more academic subject teachers to implement the curriculum.

Schools differed in the manner in which HIV instruction was integrated into the schedule. In several schools, subject teachers taught the HIV/AIDS curriculum over a concentrated six-week period. In others, instruction was spread out over the entire school year. At one large academic/comprehensive high school, HIV/AIDS lessons were conducted in selected subject areas once a month over eight months, with an additional two lessons added to the six-session curriculum.

All ten schools implemented the six lesson mandate, although the depth and breadth of HIV/AIDS education differed greatly among the ten sites visited. In certain instances, academic subject teachers viewed "integrating" HIV/AIDS into their classes as structuring their regular lesson plans around AIDS issues rather than teaching one of the six curriculum lessons (i.e., a science teacher connecting a lesson on the immune system to the HIV virus, a math teacher bringing the demographics of AIDS into a statistics lesson, or an English teacher assigning an essay about students' reactions to learning that a friend was HIV-positive.) While these examples reflect the positive potential for teachers to incorporate HIV/AIDS in their subject areas, it was unclear whether secondary references to HIV/AIDS issues were being used to fulfill rather than to supplement the six lesson requirement. The ambiguity of the Chancellor's "integration" recommendation seemed to result in different degrees of HIV/AIDS education, depending on the interpretation of each school's staff.

At one specialized high school both team members and several non-team teachers noted that some of the required lessons were only loosely incorporated into subject classes, especially when teachers had little interest in HIV/AIDS or were uncomfortable with the topic. Other schools were, however, highly committed to the lessons. Department chairs at one of the schools required teachers to submit instructional plans for review in advance. In this school, department chairs observed classes and provided debriefing sessions for HIV/AIDS instructors.

The self-assessment reports also reflected disparities in the degree to which the curriculum was integrated into the overall school program. Twenty out of the 35 schools (57%) reported that the successful integration of the curriculum was one of the strengths of their program (Table 18).

In a self-assessment report, one school team leader explained that teachers in English, social studies, and science departments had all been successfully trained to teach HIV/AIDS lessons by SPARK personnel and health education staff. In this school, ninth graders received lessons in English classes, tenth grade students in health education classes, eleventh grade

Table 18

Perceived Strengths and Weaknesses of HIV/AIDS Education Offered in Self-Assessment Reports[a]
(N=35)

Strengths	N	%
Integration of HIV lessons into curriculum	20	57
Sufficient materials and/or resources	8	23
Provisions for special populations	4	11
High quality of teaching staff	3	9
Successful outreach activities	2	6
Successful peer education	2	6
Effective use of CBOs	2	6
Successful teacher training	1	3
Weaknesses	**N**	**%**
Inadequate staff development/teacher training	13	37
Staff discomfort/inadequate preparation	5	14
Too little CBO involvement in the program	4	11
Burden on health and PE teachers	3	9
Staff resistance to the program	3	9
Outdated information	2	6
Inadequate resources/materials	2	6
Insufficient time for teams to meet	2	6
Insufficient HIV/AIDS education in earlier grades	2	6

[a] Multiple Responses were possible.

students in science, and twelfth grade students in social studies classes.

In six of the self-assessment sample schools, HIV/AIDS education was taught exclusively by health teachers or SPARK specialists. In one of these schools, respondents reported that health and physical education departments were unfairly burdened with HIV/AIDS instruction and that a more interdisciplinary approach to the subject was a goal for next year.

Site visit data revealed that the number of staff actually teaching the lessons in a single school ranged from a high of 80 to a low of six, with most schools having from 20 to 30 instructors teaching the HIV/AIDS curriculum depending on the size of the school. Staff responsible for teaching HIV/AIDS education were not, however, always equally prepared or comfortable teaching the curriculum.

The HIV/AIDS team's organization and effectiveness seemed to influence how successfully the curriculum was incorporated into subject classes. At one school with a strong team leader and supportive coordinator of student affairs, teachers seemed more aware of and involved in teaching the AIDS curriculum than at other schools, where the team leadership was not as strong. In another school where the team appeared to be having difficulties, evaluators found less accountability between the team leader and the staff assigned to teach HIV/AIDS education.

Staff cited a number of advantages to teaching the HIV/AIDS curriculum as part of an academic subject course. One coordinator stated that "students [are] more interested in the AIDS problem as a result of teaching it this way." The team leader at another school commented that "when it [HIV lessons] is integrated into the curriculum, it becomes a normal part of school and daily life rather than a special lesson, and this takes some of the stigma away." The curriculum coordinator at another school said that having the HIV/AIDS curriculum integrated into regular academic classes encouraged "participation, role playing, and small group discussion. Students can get an important base of knowledge."

The disadvantages of teaching the curriculum as part of academic courses included the belief on the part of staff at two sites that teachers were "not adequately prepared to teach the lessons." One school curriculum coordinator believed that some of the scientific and medical information in the HIV/AIDS curriculum is too outdated to integrate into biology classes. Two schools reportedly had problems teaching the curriculum in PE classes since these classes were too large for comfortable discussion of the material. At one of these schools the team leader reported that space constraints forced her to conduct some of the lessons in physical education classes.

Staff members in nine of the ten schools reported that they taught more than the required six lessons. This supplemental instruction took the form of additional HIV/AIDS lessons, special school seminars, assembly programs, and health fairs.

Staff cited a number of significant accomplishments they felt were achieved by their HIV/AIDS educational programs. Among them:

- "We've developed an exceptionally well-trained staff."
- "Students are volunteering to do peer education on an ongoing basis."
- "We've convinced our students that AIDS is a problem for inner city teens.
- "The program has given students a forum to express their fears and concerns.

SPECIAL POPULATIONS

Evaluators found that program staff used a variety of strategies for providing HIV/AIDS instruction to the LEP student population. In two schools, the bilingual SPARK resource person taught the Spanish-speaking LEP students. Another school had all lessons translated into Spanish and Chinese/Mandarin, and had lessons one and five taught in students' native languages. One team leader reported working with the Hispanic AIDS Forum to reach Spanish-speaking LEP students. In another school, the coordinator noted that the section of the HIV curriculum conducted in physical education classes was taught in both Spanish and English.

Teachers attempted to reach absentees and over-the-counter students* through presentations in the school cafeteria during lunch periods and scheduled make-up lessons. One team leader also noted that her school's policy of conducting monthly HIV/AIDS lessons meant that the over-the-counter students were more likely to be reached since AIDS instruction occurred throughout the year. SPARK specialists also made special efforts to reach over the counter students. Special education students received HIV/AIDS lessons as part of their own program of studies.

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* Over the counter students are students who were not in the New York City School system the previous year and therefore not listed on official high school records. These students did not register for school until September or later in the school year.

PARTICIPATION OF OUTSIDE GROUPS

Outside groups with established credentials in HIV/AIDS education helped teach lessons in three of the ten schools visited by OREA. All of the groups had a previous relationship with the school, CBOs (community-based organizations) such as the Bronx AIDS Network, the Henry Street Settlement, the Black Women's Health Project, and the Family Life Theater also gave presentations to students outside of classes. (See Chapter VI for a broader discussion of CBO involvement.)

Two of the ten curriculum coordinators said that they involved CBOs and other HIV/AIDS service organizations in teaching Lesson Four, "Community Responses to HIV/AIDS." Both coordinators noted that organizing these lessons required considerable legwork, and that the program's administrators should provide more assistance in identifying CBOs to assist with the topic of community response. Team leaders in four of the 35 self-assessment schools singled out limited CBO involvement as a weakness of the program (Table 18).

TRAINING

Although all but one curriculum coordinator said that some portion of the school's staff received in-service training on curriculum implementation, the length and breadth of training differed from school to school. In some schools one-hour staff development sessions took place at the beginning of the academic year; in others, "training" was limited to presentations of the curriculum at department meetings followed by a discussion.

In response to questions about additional training needs, seven coordinators requested additional teacher training. One said specifically that more non-health, academic subject teachers needed to be trained. Another similarly commented that the Chancellor should mandate that every teacher implementing the curriculum receive thorough training in HIV education. Two coordinators said that training should focus on raising the comfort level of staff in teaching HIV/AIDS lessons. Two others recommended revisions and updates on AIDS issues in both the trainings and in the curriculum. Another coordinator believed that staff needed more information about community referrals and resources.

In self-assessment reports, staff at three schools cited the high quality of their teachers as a strength of the program. Conversely, five other team leaders noted that a lack of adequate knowledge and general discomfort with the curriculum were barriers to the effective implementation of HIV/AIDS education (Table 18).

RESOURCES

Some instructional materials were disseminated to all HIV/AIDS teams by CHCs and staff of the Technical Assistance Project and other materials were provided in response to requests from individual schools. Team members were also told to contact the HIV/AIDS Resource Center or agencies on a list provided to teams.

Five school curriculum coordinators interviewed during site visits reported having adequate resources for their HIV/AIDS instruction. Three others commented that their schools had either failed to receive adequate materials or lacked the funding to purchase the resources they needed. The most common request was for more videos and other audiovisual resources. A similar split occurred with respect to the availability of materials in appropriate languages. One school with a large Asian population indicated that more materials were needed in Chinese. The team leader at another site said that her school badly needed a health textbook in Spanish to conduct more effective AIDS education with LEP students.

STUDENT OPINIONS ABOUT HIV/AIDS EDUCATION

OREA evaluators focused their interviews with students on both classroom instruction and additional HIV/AIDS educational efforts in their schools. In these interviews, the majority of both team and non-team students thought that they had learned more than they already knew about the virus as a result of the HIV/AIDS education received during the year. Thirty out of 48 students (63 percent) reported that their knowledge about the HIV virus and AIDS increased during the year. Another nine of these students (19 percent) ranked themselves as having "a great deal" of knowledge at the beginning of the 1991-92 school year, the highest of four ranks they could select. Thus, further gains in knowledge could not be measured by the instrument. Having started the year knowing "a moderate amount" or less, the remaining nine students (19 percent) indicated no gains in knowledge. As would be expected, students who were team members were more likely to report knowledge increases than nonteam students (71 vs. 50 percent).

Evaluators found a wide range of responses, however, in student perceptions about the curriculum and about the overall impact of the HIV/AIDS education program on their peers. A majority of the students believed that the HIV/AIDS education program was having a positive effect on their peers; student team members believed that the program had a greater influence than non-team students.* Out of 28 student team members interviewed, 23 (82 percent) reported that it was having a positive impact whereas only ten out of 20 students (50 percent) interviewed who were not HIV/AIDS team members said that the program had a positive impact.

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* Students were asked about the effect of the HIV/AIDS program overall including HIV/AIDS education and condom availability. Students were not asked to differentiate the effects of these two components.

The following responses highlight student's positive opinions:

- "[As a result of the program] students know more about AIDS, can protect themselves if they decide to be sexually active, can talk with someone without others knowing about it."
- "[The program has] helped to dispel myths regarding contracting the virus."
- "The program is encouraging students to be more responsible."

A number of student team members perceived that the knowledge, comfort, and biases of teachers affected their instruction and its impact on students:

- "AIDS education depends on the teacher. Some are biased and restrict discussion to certain topics. One teacher, for instance, only focused on abstinence. He was uncomfortable talking about condoms and only mentioned negative things about condoms and only mentioned negative things about condoms and sex. What we need are teachers who provide a nonjudgemental approach to education. Teachers need to realize that students are sexually active."
- "Class discussion can help get the ball rolling. It can carry over and get in people's minds. The best thing is to have an HIV-positive person speak to the group. AIDS lessons are only helpful if the presenters have knowledge and are comfortable with the issue. Teachers must have credibility."

Non-team students, although supportive of AIDS education efforts, tended to be more skeptical about the program's impact:

- "For some students, yes [it has had an impact]. For others, no. Some students just do not want to know about it."
- "[There has been] no real change in behavior [as a result of the program]."

CONCLUSIONS AND RECOMMENDATIONS

Based on data from site visits, interviews, and self assessment reports, OREA evaluators determined that significant

HIV/AIDS education efforts took place in New York City high schools during 1991-92. HIV/AIDS education teams were moving forward in developing more effective educational programs that reach a larger number of students than in prior years.

There did appear, however, to be much variation in how successfully the HIV/AIDS curriculum was being integrated into academic subject classes. In several cases, SPARK intervention specialists or teachers from the health and physical education departments served as the main AIDS educators probably because they were the best trained staff to teach an HIV/AIDS curriculum without extensive additional teacher training. In a few site visit schools it seemed that only a core group of teachers had an understanding or knowledge of the HIV/AIDS curriculum. A comment from a vocational school respondent's self-assessment report illustrates OREA's finding: "It was felt by the team that teachers who believed in the program taught it well and that those who were not supportive either did not teach it, or did not teach it well." Thus, further engagement and training of more HIV/AIDS educators in New York City high schools would improve the capacity and quality of the program.

In general, schools with organized, well-functioning teams were better at integrating HIV/AIDS education into the overall school program than other teams. Nevertheless, in each school visited, OREA was able to identify staff members who worked diligently to make sure increasing numbers of students received HIV/AIDS education.

Overall, staff interviewed expressed positive reactions to the HIV/AIDS Family Life curriculum although many curriculum coordinators and teachers augmented it with their own ideas and materials. Student team members were more likely to think the program had an effect on their peers than did student non-team members. Importantly, a large percentage of student respondents commented that their knowledge about the virus had increased since the beginning of the 1991-92 school year.

With respect to the HIV/AIDS curriculum and educational efforts in high schools, OREA offers these recommendations:

- Provide more training for staff who teach the six mandated lessons. For example, enhanced teacher trainings could be conducted, preferably within each school, led by master teachers who have been identified by New York Public school staff. Ensure that all teachers of HIV/AIDS lessons are properly trained and comfortable with the curriculum.

- Ensure that teachers who are participating in the program receive timely updates on HIV/AIDS issues and medical developments. In addition, provide training opportunities for teachers who would like to become involved in the program.

- Ensure that the Family Life Curriculum, scheduled to be updated for 1993, is reviewed on a regular basis so that it reflects the changing demographics and most recent medical developments concerning HIV/AIDS. For example, since the high school curriculum was developed in 1987, women infected with HIV through heterosexual contact have made up an increasing proportion of AIDS cases. As a result, women's issues and concerns should receive special attention in future curriculum revisions.

- Clarify the policy related to integrating the HIV/AIDS curriculum into academic subject classes. In some schools secondary references to HIV/AIDS issues in classes with other primary goals may have been used in place of, rather than as a supplement to the recommended six-lesson curriculum. Clarification is needed about the content of the HIV/AIDS curriculum that will satisfy the Chancellor's mandate for teaching the six lessons.

- Accelerate the materials review process, implemented in 1992, to provide all schools with adequate and updated publications, videos, and other resources. Ensure that these materials are culturally relevant and in appropriate languages.

- Help team leaders in develop school-based accountability procedures to ensure that HIV/AIDS lessons are being taught as mandated. Encourage schools with effective educational programs to work with schools with less well-developed programs. Pair experienced HIV/AIDS educators--from the same or different schools--with inexperienced subject area teachers to improve the delivery of HIV/AIDS instruction.

V. CONDOM AVAILABILITY

BACKGROUND

Condom availability* in high schools and classroom HIV/AIDS instruction were the centerpieces of the Chancellor's Expanded HIV/AIDS Education Program during the 1991-92 school year. Although provided with some direction through implementation guidelines (Appendix C), schools had a great deal of latitude to adapt their programs to internal conditions. Program guidelines mandated that schools designate at least one area within the school (the health resource room) to make condoms and other health resources available to students. This site was required to be staffed at a minimum of ten periods per week by at least one male and one female school employee. All health resource staff were required to participate in the Program's special Tier II training.** Schools were required to inform every student about the Expanded HIV/AIDS Education Program/Including Condom Availability, and each school was instructed to post a schedule of the hours and location of condom availability at a location accessible to all students. Schools were also required to designate a locked storage space that would protect the condoms against damage or tampering. Although there was no stipulation about the number of condoms to be given to students upon request, all of the schools visited by OREA had adopted a policy of providing students with no more than two condoms at a time.

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*In this program, condoms are available to students who request them from specially trained New York City Public School employees. In no schools were condoms "distributed" to students. That is, condoms were not given to students who did not specifically request them. Condom availability occurs within the larger context of HIV/AIDS prevention education including abstinence.

**Topics covered in Tier II training included information on adolescent sexual behavior including abstinence, condom use and misuse, and program policies. Topics covered in small groups included adolescent sexuality; communicating with teens; teaching sexual abstinence; risky sexual behaviors; condom use and misuse; negotiating with your partner; school system policies on condom availability; and identification and utilization of HIV/AIDS community resources.

Schools began the six mandated HIV/AIDS lessons at the beginning of the 1991-92 school year prior to implementing condom availability. Implementation of condom availability within the New York City Public high schools proceeded in three phases, with the first of the 17 Phase I schools beginning condom availability in November 1991. Phase II schools implemented condom availability beginning in January 1992. (Appendix A contains a list of the schools in each phase.) By June of 1992, all but 11 of the schools that participated in the Board's training made condoms available to students.

This chapter describes the implementation of condom availability in a sample of Phase I and Phase II schools. Among the topics discussed are strategies employed to inform students about the program, characteristics of health resource staff, factors influencing student requests for condoms, information and counseling requested by students, and impressions about program impact.

Data concerning implementation of condom availability were collected primarily from two sources: interviews with individuals at ten schools (including principals, HIV/AIDS team leaders, teachers and other school staff, students, and parents), and self-assessment reports submitted by schools in Phases I or II. (See the Evaluation section of Chapter I.) Findings in this section are based on data collected from schools in the first two phases, thereby ensuring that sample schools had several months of implementation experience.

INITIAL IMPLEMENTATION OF CONDOM AVAILABILITY

Implementation of condom availability occurred more smoothly than expected in each of the 10 schools visited by the evaluation team. Half of the principals (N=5) reported no difficulties. Some principals reported that their school's careful preparations paved the way for smooth implementation. These preparations included care in selecting the HIV/AIDS team members, and special activities of parents' associations. Some principals attributed smooth implementation to the competence of the team leaders. Two principals also remarked that having the program mandated lessened opposition; that is, since parents and staff knew that condom availability would occur, their discussions could focus on how the program would be implemented rather than on whether it would or should be implemented.

Several principals indicated that their programs faced logistical difficulties. One school with off-site programming found that geography was an obstacle to communication, coordination, and receiving materials. Finding space for the Health Resource Room in already overcrowded school buildings also presented problems. Sending teachers to daytime trainings, finding time for teams to meet during school hours, and in one case, prodding a reluctant administrator to act, were other implementation barriers mentioned by team leaders.

In response to a question about what surprised them the most during implementation, four of the principals reported being pleasantly surprised that students acted with maturity, seriousness, and dignity when the condom availability commenced. There were no condom balloon pranks and few inappropriate jokes. As one principal remarked, "In most cases, the students had fewer hang-ups about dealing with this subject than did the adults." Fears about interference by the media also failed to materialize. None of the principals reported that the program generated controversial issues in their schools.

DESCRIPTION OF CONDOM AVAILABILITY

Informing Students about Condom Availability

Mandate 6 states that "The schedule of the health resource space hours must be posted and accessible to all students," however, OREA evaluators found that schools used multiple strategies to let students know where and when condoms were available. Team members reported that outreach to students was important, and several thought that improving outreach would increase the number of sexually active students who would request condoms.

All of the schools posted the Health Resource Room schedule except the multi-site alternative school, where if condoms were

Table 19

Students' Reports of Methods Used to Inform Them about Condom Availability[a]

	School									
Methods	1	2	3	4	5	6	7	8	9	10
Posters	■	■	■		■		◄	■	◄	■
Flyers/handouts	■	◄	■	■	■	■	■		■	■
Peer counselors					◄				◄	■
Teachers	■	◄			◄	◄	◄	■	■	■
Guidance counselors		◄	◄		◄			■	◄	■
PA announcements	■	◄			◄		■	■	◄	■
School newspaper		◄	■	■	■	◄			■	
Word of mouth	■	◄	◄		■		■	■	◄	■

Legend: ◄ = fewer than 50% of students reported the method
■ = 50% or more of students reported the method

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[a] Multiple answers were possible.

- Schools used multiple methods to inform students about condom availability. These methods reached different groups of students.

available, they could be obtained only from the site teacher. Schools also used other techniques for informing students about the availability of condoms.

Table 19 displays student answers to a fixed-response question about how students were informed about the availability of condoms in their schools. The table displays methods reported by fewer than 50 percent of students interviewed at that school as well as those reported by 50 percent or more of those students. This analysis reveals that within any particular school, not all students become informed of condom availability in the same way.

Table 19 also shows that all of the schools used two or more methods to inform students about condom availability, but they varied widely as to the number and type of methods used (Table 5.1). One school, for example, used a digital "ticker tape" board to broadcast announcements. The school employing the fewest number of methods (school 4) was a multi-site alternative school where some of these strategies were neither appropriate nor feasible. In addition, schools differed in terms of the intensity of their "public relations" activities. For example, in one school, there were daily public address announcements about condom availability. In others, announcements were intermittent.

When OREA evaluators asked students to give their opinion about the best ways to inform them about condom availability, the most frequent replies from the 39 students responding was hearing about condom availability either from school staff (26 percent), from other students (including friends and peer counselors) (18 percent), or by word of mouth (20%) which encompassed both students and school staff (Table 20). Posters and flyers were also considered effective ways to reach students. Two students in different schools indicated that school guards had told them about condom availability at school. The absence of a clear preference among these choices suggests that multiple strategies may be needed to reach the maximum number of students.

Table 21 shows the number of schools in the self-assessment sample using these strategies. All schools used two or more strategies; one school used five. Again, several outreach strategies appear to be popular including posters and signs, flyers/handouts/letters, and announcements over the public address system. It is interesting to note that students preferred direct oral communication from school staff or other students, however, the program guidelines and team reports emphasized written methods of communication.

Characteristics of Health Resource Staff

The program's mandates provided latitude with regard to the composition of the group of faculty and school staff who would make condoms available, stipulating only that at least one male and one female needed to be selected (Mandate 7). However, the HIV/AIDS Education team from which health resource staff were drawn was to be broadly representative of the school constituencies, guaranteeing some measure of diversity. (Chapter III of this report discusses HIV/AIDS teams.) Some school teams established their own priorities with regard to having health resource staff of different race/ethnicity and with different positions in the school (i.e. administration, faculty, and pupil personnel services).

All of the schools in the self-assessment and site visit samples had both male and female health resource staff, and in both samples approximately

Table 20

Students' Opinions about the Best Ways to Inform Students about Condom Availability[a]
(N=39)

Method	N	%
School staff	10	26
Word of mouth	8	21
Students, friends, peer counselors	7	18
Posters	7	18
Flyers, handouts	5	13
Public address announcements	3	8
Newsletter	2	5
All of the above	1	3

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[a] Multiple answers were possible; nine students did not answer the question.

- School staff, students and word of mouth were the most frequently mentioned sources of information about condom availability.

Table 21

Self-Assessment Reports of Methods Used to Inform Students about Condom Availability[a] (N=23)

Methods	N	%
Posters and signs	16	70
Flyers, handouts, letters to students	16	70
Announcements over the public address system	14	61
Announcements by teachers in class, or announcements (not otherwise specified)	6	26
Word-of-mouth	4	17
Student newspaper/newsletter	3	13
HIV/AIDS lessons	2	9
Classroom discussions	2	9
Peer educators	2	9
Letter to parents	2	9
Electronic phone call to home	1	4
Classroom visit	1	4
Video	1	4

[a] Multiple answers were possible.

- More than sixty percent of the 23 schools in the sample reported using posters and signs, printed materials such as flyers and handouts, and announcements over the public address system to inform students about condom availability.

two-thirds of these staff were female and one third were male. Among the 17 schools in the self-assessment sample that reported the number and gender of these staff, both the mean number of staff per school and median were 10; the number of volunteers per school ranged from three to 30. Overall, of the 164 health resource staff in these 17 schools, 63 percent (N=104) were female and 37 percent male (N=60).

In the site visit sample the mean number of health resource staff per school was 12 and the median was 10. The number of staff per school also ranged from three to 30. Of the 119 staff whose gender was reported, 60 percent were female (N=71) and 40 percent were male (N=48). The alternative high school (with multiple sites) had the largest number of health resource staff because most of the site teachers had volunteered to make condoms available. Among the vocational/technical and academic comprehensive high schools, those with the greatest number of health resource staff had active, high-profile HIV/AIDS programs. Schools with fewer health resource staff tended to have programs much more narrow in scope in terms of extra awareness activities, integration of HIV/AIDS instruction into academic classes, and general visibility of HIV/AIDS-related information in the school.

There was some speculation among health resource staff that boys and girls both preferred to request condoms from women, but that boys will also request condoms from males. It was generally felt that girls were more uncomfortable requesting condoms from adult males.*

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*Because the schools were not required to collect these data, the evaluation could not test these hypotheses.

As indicated in Table 22, health resource staff included administrators, academic staff, and those involved in pupil support (such as guidance and SPARK counselors). Note, however, included in the table are only those individuals interviewed during site visits (54 of 119 health resource staff in these 10 schools). Regrettably, we do not know whether the individuals interviewed were representative of the health resource staff in these schools overall.

Teams endeavored to have health resource staff who, as a group, represented the ethnic and racial diversity of the student population in their schools. However, in seeking out condoms and information, students appeared to be more concerned with the rapport they felt with the staff than with their race or ethnicity. To this end, it appeared that many of the health resource staff had professional experience in health and sexuality education and/or in guidance and counseling roles with students--backgrounds that might enhance rapport.

Moreover, ensuring that health resource staff matched the ethnicity of students may have had the opposite of the intended effect (namely, to have staff that are more approachable). According to one female Hispanic and one female Chinese health resource staff, Hispanic and Chinese students do not seem to seek out female staff of the same ethnicity. These staff thought that students might view them as symbols of strong cultural prohibitions against premarital sex. It is also possible that staff were approached by fewer members of certain ethnic groups because the rates of sexual activity among these groups were lower than those of other students, or because these students obtained condoms elsewhere. Further research

Table 22

Job Titles of Health Resource Staff Interviewed during Site Visits

(N=54)

Job Title	Number of Health Resource Staff
Administration	
AP Guidance/PPS	2
AP Administration	1
Faculty	
Health and PE[a]	6
Other teachers[b]	12
Special education	3
Librarian	1
Student Support	
Guidance counselor	10
SPARK Staff	9
COSA	4
School psychologist	1
Social worker	2
School aides and paras[c]	3
Total	54

[a] Teacher or coordinator

[b] Other teachers included those teaching English, math, science, social studies, music, arts and communications, speech, shop, home economics, electronics, and a site teacher in the alternative school.

[c] Includes school aide, family paraprofessional, and school neighborhood worker.

would be needed to determine whether other female Hispanic and Chinese staff had the same experience, and if so, why.

Location of Condoms: Health Resource Rooms and Satellite Sites

Mandate 3 stated that "Each school is required to designate at least one area within the school (not the school-based health clinic) where condoms and other health resources will be made available. The space should offer privacy and should be outfitted with information on HIV/AIDS, sexually transmitted diseases, and other health issues." Program guidelines indicated that condoms could also be made available at additional sites such as the guidance counselor's office.

Eight of the 10 schools visited by OREA had several Health Resource Rooms; only two had one Health Resource Room, only, and no other sites for condom availability. These rooms were dedicated exclusively to the dissemination of health information and condom availability. The unanticipated consequence of having a single site, as reported by school staff and students, was that it became known as the "condom room." Although both of these rooms had many posters and brochures on multiple health-related topics, the redesignation of the room in conjunction with condom availability pegged it as a single-purpose room. As a result, student privacy was compromised and students seeking only information sometimes avoided these rooms for fear of being identified as sexually active. This was particularly true for female students, who were reportedly more concerned than the males with "protecting their reputation." The daunting limitations of a single Health Resource Room were obvious in one school with limited hours of availability where students sometimes had to request a pass from a classroom teacher to visit the room. Health resource staff at that school reported that few students used the health resource room, and students reported that they preferred to obtain condoms from drug stores.

The mandate requiring health resource rooms also was impractical for the multi-site alternative school where students combined academic work with on-the-job training. A health resource room could not be designated due to the special features of the program and its location at work sites. At this school, trained site teachers were reported to be functioning effectively in making condoms available; however, the lack of anonymity was reported by the team leader to be a drawback for some students.

Eight of the ten schools visited and most of the self-assessment sample reported that they had designated several "satellite sites" within the school where students could go for condoms. "Satellite sites" were sometimes medical rooms (not school-based clinics), assistant principal offices, guidance offices, social workers' offices, physical education offices, COSA (Coordinator of Student Activities) offices, SPARK offices, the library, and academic classrooms.* In one school, a City Maternal-Infant Care site serving pregnant and parenting teens in the school was designated for condom availability. Students were unable to obtain condoms at the school-based clinic at one of the schools, pursuant to a Board of Education prohibition against the availability of birth control in school-based clinics.*

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*Academic classrooms designated as health resource sites included a special education class, a home economics room, a social studies room, and a computer lab. Condoms were made available when the room was not being used for classroom instruction.

Evaluators visiting both health resource rooms and satellite sites found that brochures on HIV/AIDS and a variety of other health and safety topics were available to students at all locations. In both types of sites, there were HIV/AIDS posters on the walls of waiting areas and offices. The single-purpose health resource rooms, however, had a much more abundant supply of materials on a broader range of topics. Wall displays were often crafted by students and displayed risk-reduction messages and information about community-based and city resources (e.g. for HIV testing, counseling, and health care).

HIV/AIDS Education Teams attempted to locate condom availability in sites convenient for students. However, as one student told the interviewer, "There is no favorite spot. It's always embarrassing to get condoms." Comfort in requesting condoms from particular individuals appeared to be the key to obtaining condoms, rather than location, per se. Responding to a question on the preferred location for condom availability, one student referred to what he called the "trust and embarrassment factor" as a determinant of where he thought students preferred to obtain condoms. Five students specifically mentioned that the reason they preferred a particular location was the person rather than the site. Students specifically mentioned the COSA (who was "less of a teacher more of an advocate"), the guidance counselor, and "popular administrators."

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*This policy was amended beginning in October 1992 and school-based health clinics now must make condoms available to students requesting them.

"Friends" was the most popular response (38 percent) to the interview question, "Where do students prefer to get condoms." Reasons for preferring friends included trust, convenience, comfort, less embarrassment, and the fact that the relationship was more personal. Table 23 indicates that after friends, health resource rooms, other locations in the school sites, and drug stores were the most frequently cited sources of condoms. Students who preferred the health resource room said this was because they had a good relationship with the staff who were there, and because it was a multi-purpose site. At another school, a student remarked that the health resource room needed to be more private. Students who preferred the nurse's office indicated that it was easy to find and a place that students were used to going to for other medical problems.

Several students remarked that they were uncomfortable asking teachers for condoms because they did not always want teachers to know they were sexually active. However, two students commented that although it was easier to obtain condoms from a friend or a drugstore, they valued the fact that teachers explained the proper way to use condoms.

Table 23

Students' Preferred Locations for Condom Availability (N=37)

Location	N	%
Friend	14	38
School staff - not in health resource room[a]	8	22
Health resource room	7	19
Drug store	5	14
Community health clinic	1	3
Other[b]	2	5
Total	37	101%[c]

[a] This response refers to a health resource staff person in a satellite site in the school.

[b] Other locations included the cafeteria and a community center.

[c] Does not equal 100% due to rounding.

Note: Four students did not answer the question, primarily because they indicated that the qualities of the person were more important than location. Seven students provided multiple responses, even though the question asked them to choose only one. Those responses included: friend (3), health resource room (4), school staff (3), drug store (2), health clinic (1), and other (3).

- More than one-third of the students would have preferred to get condoms from a friend. Community-based health clinics were comparatively less popular.

A few students noted that students required a mix of places for obtaining condoms because their needs differed. Some seeking complete anonymity said they preferred drugstores while others who were comfortable with the health resource staff at the school sites.

Hours of Condom Availability

According to Mandate 4, "The health resource site must be staffed a least ten periods each week at a variety of times during the school day." Guidelines encouraged schools to arrange more staffing time, if possible, and permitted them to make condoms available before and after school.

The time of day preferred by students for obtaining condoms appeared to be during lunch periods and at the end of the day. In the 10 self-assessment reports responding to a question about time preferences, five (50 percent) indicated student preferences for lunchtime and three (30 percent) thought afternoons were the preferred time. In two of the schools (20 percent), students reportedly had no preference. One of the schools experimented with making condoms available before and after school hours, but discontinued these hours because they were not used by students.

Schools with single-purpose health resource rooms, only, had the most limited number of availability hours. Staff in one of the smaller schools with a single-purpose Health Resource Room complained that assignment to that room was not a productive use of their time because it was used by few students. Consequently, the health resource staff interviewed at this school reported that they were reconsidering their willingness to volunteer the following year.

In contrast, use of classrooms and offices as satellite sites expanded availability enormously, since teachers and staff could be found in these sites several periods a day. Staff were able to accomplish other duties if students were not requesting condoms, and they seemed much more pleased with their roles as health resource staff.

Factors Influencing Student Requests for Condoms

As discussed above, the mandates for the Expanded HIV/AIDS Education Program addressed hours of condom availability, gender of health resource staff, and the establishment of a health resource room.

On the basis of student interviews, these appear to be of secondary importance in influencing student requests for condoms, compared with staff-student rapport and trust and the privacy afforded by the site's location.*

Confidentiality and the personal traits of the health resource volunteer were considered more significant by staff who were close to the program (Table 24). Of the 22 staff responses to a self-assessment question concerning the factors influencing student requests for condoms, 23 percent mentioned confidentiality and 18 percent mentioned personal traits of the volunteer. Only nine percent mentioned the time and location of condom availability, factors addressed by the mandates.

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*Privacy appeared to be less significant for male students in the school with a predominantly male student population.

Interviews with health resource staff confirmed that the most significant factor influencing student requests for condoms was rapport with and trust in the staff. In addition to the reasons listed in Table 24, health resource staff indicated that students also requested condoms because there was peer pressure to do so, and that among some students it was considered "macho" to ask for condoms. As will be discussed in the next section of this chapter on trends in student requests for condoms, health resource staff reported that initial requests were prompted by curiosity about the program.

Reasons for not requesting condoms were, for the most part, the converse of reasons proffered for requesting them. The most frequently mentioned reasons given by health resource staff for nonuse of the program by sexually active students were embarrassment; fear that teachers, parents, and/or students would find out they were sexually active; lack of privacy; and feelings of invulnerability or denial. Problems relating to the location of the health resource room, its uninviting ambiance, and limited hours were also named. In one school, a student said that other students did not request condoms because they were often rushed for time. Other reported reasons for nonuse of the program were student views that condom use was not macho, the belief that the quality of the condoms was poor, or a negative experience with condoms. One volunteer commented on the misconception among

Table 24

Teams' Self-Assessment Reports of Factors Influencing Student Requests for Condoms
(N=22)

Factors	N	%
Student Factors		
Sexually active or thinking about it	2	9
Prevention of pregnancy or disease	2	9
Fears, concerns, feeling vulnerable	2	9
Age (older students)	1	5
Gender (male)	1	5
Program Factors		
Confidentiality, privacy	5	23
Personal traits of volunteer	4	18
Class discussion, education	3	14
Time and location	2	9
Respect shown students	1	5
Ability to have questions answered	1	5
Race and gender of the volunteer	1	5
External Factors		
Newsworthy events	2	9
Partner's requests, peers	2	9
Seeing condoms reminds them	1	5

[a] Multiple answers were possible.

- Staff members close to the program cited confidentiality/privacy and the personal traits of the health resource staff most often as the factors influencing students' requests for condoms.

students that if they have a regular partner they don't need to use condoms.

Trends in Student Requests for Condoms*

It was the impression of HIV/AIDS team leaders and health resource staff that requests for condoms were brisk when schools first made them available, but later slackened considerably when the novelty faded. (In one school, demand was initially low because of a rumor that health resource staff were taking students' names and reporting them to their parents. Once the rumor was dispelled, requests picked up and then dropped off, as in other schools.)

Table 25 displays the impressions of health resource staff, half (55 percent) of whom agreed with the team leaders' assessment that requests were first high and then decreased. One fifth reported that demand was steady, while a slightly smaller percentage said that demand fluctuated.

Some staff thought that decreases in requests were a result of an increase in abstinence. Staff in several schools noted,

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*During the initial months of condom availability, few schools kept statistics on the number of condoms requested, the gender of the student making the request, or the date of the request. The Central Administration and most teams decided not to collect such information to prevent student impressions that privacy was not protected and to avoid burdening the volunteers with paperwork.

Table 25

Health Resource Staff's Assessments of Numbers of Requests for Condoms
(N=40)

Request for Condoms	N	%
Initially high, then decreased	22	55
Initially steady, then decreased	1	3
Varies - more than one increase and decrease noted	7	18
Steady	8[a]	20
Increasing numbers of requests	2	5
Total	40[b]	101[c]

[a] Includes one response that the number of requests from boys remained steady, but that requests from girls were increasing.

[b] Six additional staff members indicated that the numbers of requests they received were too small to comment on.

[c] Percentages do not add to 100% due to rounding.

- In more than half of the schools, the number of requests for condoms was initially high and then decreased.

however, continued high numbers of pregnancies at their schools.*

Team members stressed the need to assure that students had access to all forms of HIV/AIDS prevention information including condom usage. The Program continued to stress that the only 100 percent effective way to prevent the sexual spread of HIV is to abstain from sexual intercourse. At the same time, the Program was also attentive to ensuring that sexually active students felt comfortable asking for condoms. A number of health resource staff expressed grave concerns, however, about the segment of students in their schools whom they believed were active sexually who were not requesting condoms. Team members interviewed identified strategies they had used or were planning to try to make condoms more accessible to sexually active students, such as better outreach or adjustments in the schedule for condom availability.

The precise proportion of girls and boys requesting condoms is unknown. However, according to half (5 of 11, or 45 percent) of the health resource staff who offered information about the gender of the students requesting condoms from them, there were roughly equal numbers of boys and girls. Four staff members (36 percent) reported that requests were mostly from boys, and two staff members (18 percent) had requests only from boys.

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*One teacher remarked that since the implementation of condom availability, students were more likely to confide in teachers about their pregnancies. As a result, an apparent increase in the number of pregnancies was actually an artifact of more open communication engendered by the program.

Student Requests for Information and Counseling

Over the course of the site visits, the evaluators gained the impression that the lines of communication on the topics of HIV/AIDS and sexuality had opened significantly between students and many program staff. A variety of factors were seen as contributing to this, including the boldness of the condom availability initiative which promoted the idea that HIV/AIDS must be a serious threat, teachers' straight-forward approaches, giving students language to use when discussing sexuality, creating opportunities for communication in HIV/AIDS Education classes, and by designating health resource staff.

According to Program protocols, all students requesting condoms are to be provided with a manufacturer's instruction sheet and a card listing the risks of use and misuse of condoms. Health resource staff reported that students requested additional information and counseling from them, but generally not at the same time they requested condoms. This was understandable both because lunchtime is a popular but hurried time for students to drop in for condoms and some availability sites were places where students tended to congregate, thereby affording little privacy. When staff must attend to the many students crowding their offices, they had limited time to give to individual students. Several of the staff members indicated that some students returned at quieter times to ask questions or discuss concerns. Others indicated that the condom availability site was not the only place that students requested information. Students reportedly also raised questions and concerns during HIV/AIDS education classes or during SPARK programming.

Eleven health resource staff from seven of the ten schools in the site visit sample, noted that they initiated discussions with students even if students were reticent. Several staff noted that they made special attempts to talk to students who had not requested condoms from them before. One staff member said, "If its the first time they are requesting [condoms], we try to talk to them and have them spend a little time with us." A staff member at one school thought that girls often asked questions before they requested condoms as a way to "check [the health resource staff] out," that is, to determine whether they would feel comfortable asking them for condoms.

Students asked health resource staff questions on a wide range of topics including responding to peer pressure to have sex, general HIV/AIDS information, the risk of the transmission of HIV through oral sex, HIV testing, proper use of condoms and their effectiveness, pregnancy, sexually transmitted diseases, and establishing paternity. Two of the staff members told evaluators that they had each counseled students with parents who had AIDS. In response to a student's disclosure of a "serious situation," a volunteer helped the student get tested for HIV infection.

Whether or not students had counseling needs, evaluators assessed whether students felt there was someone in the school they could turn to with personal questions about HIV/AIDS should the need arise. Almost all of the students (92 percent) said there was someone in the school whom they felt comfortable going to with personal questions; only four of the 48 students interviewed (8 percent) said there was no one they could approach. Teachers were the most frequently mentioned (42 percent), followed by counselors (33 percent) (Table 26).

A total of 11 students (38 percent) said either they had no one to go to with personal questions (N=4) or their resource were exclusively nonadult (i.e. friend or peer counselor) (N=7).

IMPRESSIONS ABOUT PROGRAM IMPACT

Team leaders were asked their opinions about the impact of the Expanded HIV/AIDS Education Program/Including Condom Availability program on students. Their answers addressed the impact of the entire program implemented in their schools, rather than individual components (i.e., HIV/AIDS lessons, condom availability, peer leadership programs, or special events).

Team leaders indicated that the program had a positive impact in the areas of heightened awareness, increased openness and better communication, and mutual respect.

Heightened Awareness

Students' awareness of the dangers of HIV infection was reportedly heightened and more students were aware of behaviors that put them at risk of infection.

Increased Openness and Better Communication

Several team leaders indicated that communication between students and school staff improved as a result of the program. One said that "Students with HIV-positive family members were

Table 26

Student Reports of Persons in the School Whom They Would Feel Comfortable Going to with Personal Questions about HIV/AIDS[a]

(N=48)

Person	N	%
Teacher	20	42
Counselor	16	33
Friend	15	31
Peer Educator	6	13
Nurse	2	4
Other[b]	6	13
No one	4	8

[a] Multiple answers were possible.

[b] Other responses included COSA (2), cheer leading coach (1), teacher from prior a year who no longer teaches at that school (1), sister (1), and parent (1).

- Approximately two-fifths of students reported that they were most comfortable going to teachers with personal questions about HIV/AIDS and one-third felt comfortable seeking out school counselors or friends.

very happy to have someone to talk to." Another team leader said that the program provided an opening for students to talk to staff they now trusted about "issues of sexuality and drug abuse that they would not ordinarily have done." One team leader attributed an increase in the number of referrals made to outside agencies directly to an increase in the number of students coming forward with problems.

One team leader saw condom availability as a "carrot" used to engage students in discussion. In this view, the more important purpose of condom availability was to spark discussion and education rather than to merely increase use of condoms among sexually active students.

Team members also reported that they were now more aware of students talking to other students about risk reduction -- delaying sexual activity, reducing the number of partners or using condoms. In one school, students were overheard talking about negotiating skills.

Mutual Respect

In the words of one team leader, the program was meaningful because "Students said this was the first time they were treated like mature people and that their humanity was acknowledged." In students' opinions, this program was valuable as a demonstration of respect by staff which was returned by students who responded to the condom availability component with seriousness and maturity.

CONCLUSIONS AND RECOMMENDATIONS

There were wide differences in the scope of schools' condom availability programs ranging from those meeting the minimum requirements of the Chancellor's mandates, to high-profile, multifaceted programs involving large segments of the school community. Compared with low-profile programs, active programs tended to have more visible student participation, displays in the hallways devoted to HIV/AIDS prevention, and numerous satellite sites for condom availability in addition to the health resource room. In general it appeared that staff were more satisfied with their involvement in high profile schools. Two of the low profile programs had more active parental involvement. It is possible that high-profile schools had prior experience working in the area of HIV/AIDS education whereas low-profile schools were beginning from scratch.

New York City was the first city in the country to implement a condom availability program and schools in the sample were among the first schools to undertake this initiative. Therefore, schools' programs were developed without benefit of information about what works and there was great curiosity about other schools' experiences implementing the program.

Health resource staff included academic teachers, administrators, and student support staff (such as guidance counselors, COSAs, and SPARK staff). The number of staff per school ranged from three to 30, from the smallest number needed to make condoms available for the minimum mandated time, i.e. ten periods per week, to a large number of staff extending availability throughout the entire week. Of the ten schools visited, the alternative school had the greatest number of health resource staff because the majority of site teachers volunteered to make condoms available.

Comfort with the health resource staff appeared to be the most significant factor in student requests for condoms. Some students initially sought staff they did not know but returned as "regulars" once trust and rapport were established. Students reported feeling comfortable with academic teachers as well as student support staff. In fact, when students were asked if there was someone in the school who they could go to with personal questions about HIV/AIDS, teachers as a group were named most often, followed closely by student support staff.

Students infrequently requested information from health resource staff at the time they requested condoms. Reasons given by students and staff include lack of privacy, embarrassment, and students being in a rush. Nevertheless, some staff members indicated that when students asked for condoms for the first time, they engaged students in discussion to ensure that they knew how to use condoms properly. Staff reported that some students return later to talk. School staff who were interviewed believed that as a result of the Expanded HIV/AIDS Education Program, students had become more comfortable talking to them about troubling problems. It was reported that students discussed sexuality and drug abuse issues with health resource staff more often than before the program. Principals and health resource staff were surprised by the number of students who confided about family members who were HIV positive or who had AIDS.

Eight of the ten schools visited by the OREA evaluators established a health resource room and in two of these schools it was the only place where condoms were available. The alternative school in the sample did not set up a health resource room because students attended school at multiple work sites rather than a single school building. In eight other schools (including one without a health resource room) satellite locations were designated for condom availability. Health resource rooms established at the time this program was implemented were referred to by students and staff as "condom rooms." Although there were brochures and posters on many different health topics, use of the room by students was seen as condom-related. As a result, the room was probably avoided by students who did not wish others to think they were sexually active. The satellite sites afforded various degrees of privacy, on the whole, they appeared to be both more comfortable for students and convenient for staff than health resource rooms.

Program mandates and guidelines should be adapted to the needs of certain alternative schools and special programs. More specifically, the program mandates related to the establishment of a health resource room, hours of condom availability, and designation of a male and female health resource staff did not apply to the multi-site alternative school. In this school, students were sent to work sites dispersed throughout the city where a single site teacher educated and supervised students.

No precise data exist about how many condoms were requested or the characteristics of students who requested them. Team leaders in half of the schools visited, estimated that requests for condoms, were at first numerous, then fell and stabilized. In almost one forth of schools, requests fluctuated, and in the remainder demand was constant. By the end of the school term it appeared that condom availability program was being utilized by a small group of students relative to the probable number of students who were sexually active. Overall, more boys than girls requested condoms although some individual staff members saw similar proportions of boys and girls. Until schools collect data on these variables, precise information will be unavailable about the level of requests, gender of students requesting condoms, how demographic characteristics of the health resource staff influence demand, and trends over time.

It was clear that most students were not asking questions about the use and misuse of condoms at the time of their requests, nor do the logistics lend themselves to meaningful discussions about abstinence. Therefore, in addition to ensuring that some of the sites for condom availability provide a measure of privacy, it is very important to provide opportunities for discussion and questions in classrooms and at special events (e.g. theater group performances).

The attitudes and involvement of students were integral to the schools' success at HIV/AIDS prevention. Attitudes of peers played a role in setting norms about abstinence, sexual activity, and use of condoms. Students informed other students about condom availability and students who were not intimidated by requesting condoms sometimes brought shy friends to health resource sites. Students turned to their friends for information and advice. It is important, therefore, to continue to ensure that students have a voice in planning and implementation. Moreover, student leaders from the various informal student groups in a school should receive special training and education to ensure that they are well-informed resources for their friends.

Finally, in schools with active, well-functioning condom availability programs, it appeared that there was also an organized strategy for providing HIV/AIDS education to students, and other HIV/AIDS prevention activities sponsored by the school.

On the basis of these conclusions, OREA offers the following recommendations:

- Revise the program mandates and guidelines to reflect the special conditions in alternative schools and special programs.
- Provide more training to help some health resource staff become more "askable" and sensitive to students' concerns. Work with staff to create a climate in health resource sites that is comfortable for students who want to talk about a matter of importance to them or to obtain more information. This includes ensuring that there are private spaces for these conversations.
- Encourage the establishment of multiple sites for condom availability in schools in locations that are accessible to all students. Program planners should stress to schools the importance of ensuring that many of these sites be conducive to private conversation between student and health resource volunteer.
- Expand opportunities for student involvement in HIV/AIDS programs. Student participation can be strengthened by an expanded role in outreach, dissemination of information, peer education, and leadership training.

VI. COMMUNITY-BASED ORGANIZATIONS (CBOS) AND CBO-RELATED RESOURCES AND MATERIALS

This chapter describes the involvement of community-based organizations (CBOs) and other outside agencies in providing resources and materials to high schools participating in the Expanded HIV/AIDS Education Program/Including Condom Availability. The findings reported in this chapter are based upon data from interviews conducted with staff members, students, and parents at the 10 schools in the site visit sample.

BACKGROUND

CBOs have had a presence in the New York City public schools over the past two decades, and have played a significant role in curriculum enhancement, particularly in the areas of teen pregnancy prevention, sexually-transmitted diseases prevention, and alcohol and substance abuse prevention. In 1990, the Board of Education's Office of Health convened an Ad Hoc Advisory Council on HIV/AIDS which included many CBOs. This was the first time CBOs were systematically organized around HIV/AIDS educational issues.

In his HIV/AIDS implementation guidelines, the Chancellor encouraged the continued involvement of community-based organizations in the Expanded HIV/AIDS Education Program/Including Condom Availability by promoting their inclusion on the school-based HIV/AIDS teams. For many high schools (particularly the alternative high schools), this represented a natural "next step" in their relationships with CBOs.

CBOs enriched HIV/AIDS programmatic efforts in schools through presenting musical and dramatic productions, running peer education programs, making referrals to community-based medical and social service agencies, assisting with BASE grant projects (defined in glossary), participating in health fairs, providing guest speakers, and publishing educational materials designed for adolescents. As discussed in Chapters II and III of this report, they were also instrumental in planning and conducting the HIV/AIDS team training, and often assisted school staff in teaching the six mandated HIV/AIDS lessons.

CBO INVOLVEMENT IN HIV/AIDS PROGRAMS IN 1991-92

Principals and team leaders in all 10 schools were asked to describe CBO involvement in their HIV/AIDS programs during the 1991-92 academic year. As indicated in Table 27 both principals and team leaders at nine of the ten schools (a total of 18 of the 20 possible respondents) stated that CBOs were involved in their schools' educational programs during the 1991-92 academic year (although one principal and team leader incorrectly identified SPARK as a CBO). Among the principals and team leaders in the nine schools, all nine of the principals, but only seven of the team leaders, were able to identify the CBOs, by name. This finding was somewhat surprising since the team leaders should have been directly involved in procuring CBOs.

Table 27

Principal and Team Leader Reports of CBO Involvement during the 1991-92 School Year

	Principals (N=10)		Team Leaders (N=10)		Total (N=20)	
Respondents who:	N	%	N	%	N	%
reported CBO involvement in their programs during 1991-92	9[a]	90	9[a]	90	18	90
identified participating CBOs by name	9	90	7	70	16	80
were certain that the CBOs named were involved with their programs prior to 1991-92	6	60	4	40	10	50

[a] The principal and team leader at one high school incorrectly identified SPARK as a CBO.

- Community-based programs were involved in nine of the ten schools in the site visit sample. According to principals in six of these schools, CBOs had been involved with their programs prior to 1991-92.

Six of the nine principals also reported that these CBOs had been involved in their schools prior to the 1991-92 school year.

The nine principals and seven team leaders were asked to name the CBOs utilized by their schools during 1991-92. In all, they named seven HIV/AIDS-related social service organizations, six hospitals and clinics, three "other" non-profit organizations, one NYS and one NYC public health agency, and a performing arts group. In addition, four other organizations were referred to sketchily and, therefore, could not be properly categorized. Table 28 presents the identified CBOs by type. An equal number (65 percent) of the respondents named HIV/AIDS-related agencies and hospitals or clinics as participating in their programs--findings which correspond to the aforementioned organizational tallies. Eighteen percent also mentioned "other" non-profits and city or state agencies.

Five principals and three team leaders identified barriers to CBO involvement in their schools. A principal and team leader from one school complained that CBOs had asked for speakers' fees (in the form of "donations") before they would come to the school. There had been no money to fund these "donations" so the school was unable to involve them. The principal suggested that the New York City Public School System should release more discretionary funds to its schools to cover such unanticipated programmatic expenses. (Another solution to this, as one principal pointed out, was for a school to secure corporate donations for its HIV/AIDS program.)

Table 28

CBOS and Other Outside Agencies Named by Principals and Team Leaders, by Type

Type of Organization	Total Named
HIV/AIDS-related agency or organization	7
Hospital/Clinic	6
City or state agency	2
Performing arts	1
Other non-profit organization	3
CBO - type unknown	4
SPARK[a]	1

[a] The principal and team leader at one school incorrectly identified SPARK as a CBO.

- Most of the CBOs participating in the nine school HIV/AIDS education programs were HIV/AIDS-related organizations, hospitals or health clinics.

One principal and one team leader, from different schools, had both found it difficult to reconcile their schools' scheduling needs with the CBO representatives' schedules, but could think of no immediate solution to this problem. A principal and team leader, from different schools, were both annoyed about the approval procedures for CBO procurement. One had tried, and failed, to use a CBO that was not on the HIV/AIDS Education Program's approved list, and suggested that the administration be open to CBO recommendations from the high schools. The other had encountered severe delays in getting her team to approve the use of a CBO, but offered no resolution to this problem.

One principal remarked that a Board of Education resolution had prohibited her team from using the school-based health clinic staff as condom volunteers, and that this situation would not change until the resolution was overturned.* Another revealed that there were no HIV/AIDS-related CBOs dealing with adolescents in his school's middle-class neighborhood which also had a large population of senior citizens. This observation underscored the problems that arise when the needs of a high school and its surrounding community differ.

REPORTED RESOURCE NEEDS

In addition to answering OREA's specific questions on CBO involvement in the schools, some staff, student, and parent interviewees mentioned CBOs and related issues in response to other questions. Their answers concerning the ongoing resource needs of their schools' programs are presented below.

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* This policy was amended in October 1992, school-based clinics now must make condoms available to students as part of the Expanded HIV/AIDS Education Program.

When describing their schools' ongoing needs for resources, some respondents mentioned the need for services that were provided by CBOs. For example, a popular resource request was for PWA (people with AIDS) speakers, with 12 staff members and five students/parents asking for this.* As one student remarked: "...[we should] have a day where the school brings in someone who has AIDS to speak with us. It would have an effect on everybody." Eighteen staff members and six students/parents also wanted other types of CBO speakers (e.g., medical professionals, HIV/AIDS advocates) to visit their schools. Interestingly, four staff members and 27 students/parents voiced the need for more information on community-based referral options for HIV-positive students and their families--underscoring the need to disseminate this information as the epidemic intensifies. In recognition of the need to continue to reach out to adolescents, six students/parents and four staff members wanted more peer educators to be trained in their high schools, and six staff members and two students/parents requested additional performing arts presentations.

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*For this analysis the responses of students and parents were grouped as were those of school staff.

REPORTED MATERIALS NEEDS

In response to questions concerning the ongoing needs of schools for HIV/AIDS educational materials, some staff members and students talked about CBO materials specifically designed for adolescents. Rarely were they able to identify educational materials, by title, but they were usually able to describe them, by type.

When discussing which HIV/AIDS educational materials were currently being used in their schools, students related the following:

- "...pamphlets on how to protect yourself and on how to put on a condom..."
- "I took pamphlets and read a lot about sexually-transmitted diseases."
- "...cards with 1-800 HIV/AIDS groups' telephone hotlines."
- "...pamphlets that were helpful regarding transmission, testing, and support groups."

However, a total of 41 staff members and 10 students underscored the need to update these educational materials (e.g., pamphlets, brochures, posters, videos) to adequately reflect the changing nature of the epidemic. Twenty-six staff members and two students requested more HIV/AIDS videos (including bilingual ones) designed for adolescent audiences. In addition, fourteen staff members and one student expressed general concern about the lack of multilingual editions of all of the educational materials.

The remarks of staff members illustrate some of their schools' specific needs:

- "Maps of areas with reported [HIV/AIDS] cases would make the statistics more real."
- "We need more medical brochures for our health resource room."
- "Many students took copies of the pamphlet, 'Students Have the Right,' until the Board of Education required us to remove it."

Another staff member was disappointed that she never received a condom demonstration video promised to her by the HIV/AIDS program's central office staff.

Several staff members identified barriers to obtaining HIV/AIDS educational materials. Some complained that their schools were given insufficient funds to purchase such materials. Others had found it difficult to procure them, and wanted the HIV/AIDS Education program to order all materials, centrally, and then disperse them to the high schools. Several staff mentioned that their schools had been able to order their own supplies, but could have used assistance in paying postage and delivery charges. Finally, a few asserted that the Central Administration had been too slow in implementing its HIV/AIDS materials review process and, thus, had failed to provide the necessary guidance to teams as they struggled to select appropriate educational materials for their students.*

CONCLUSIONS AND RECOMMENDATIONS

It is clear that community-based organizations and other agencies have enriched the Expanded HIV/AIDS Education

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* As of this date, the process for materials review has been strengthened and two lists of approved materials have been distributed.

Program/Including Condom Availability. They have educated staff, students, and parents on the medical aspects of the epidemic, on prevention techniques, and on health and social services available to HIV-positive individuals and their families. CBOs are also an important source of educational materials--particularly multilingual ones--and of performing arts presentations and peer education trainers.

It is apparent from the remarks of principals and team leaders at the ten site visited schools that CBO involvement in the 1991-92 HIV/AIDS Education Program/Including Condom Availability had been significant. Eight of the ten schools had ongoing relationships with at least one CBO, and, in six of nine schools, these relationships predated 1991-92. According to respondents, hospitals and HIV/AIDS-related social service organizations were the most frequently utilized CBOs, underscoring program participants' continuing desire for updated information on the epidemic. Public health agencies and other non-profits (some of which were ethnic organizations) were also popular CBO choices.

Schools did encounter some barriers to involving CBOs in their programs, but rarely did these derail their programmatic efforts. The need for additional school system funding to pay for CBO presentations, and streamlined CBO approval methods, were two suggestions of principals and team leaders to facilitate CBO participation. Other schools clearly needed encouragement and assistance in seeking out CBOs in their schools' geographic areas, and in being more flexible in accommodating the schedules of CBO representatives who were willing to visit their schools.

Staff members, students, and parents commenting upon their schools' ongoing needs for CBO-related resources and materials were quite specific and sophisticated in their responses. Forty-one individuals requested additional CBO representatives to speak to assemblies and Parent Association groups on HIV-related topics, with 17 of the 41 specifically asking for PWA (Persons with AIDS) speakers. Thirty-one respondents also asked for more detailed and updated information on CBOs to which HIV-positive students and their families could be referred. In recognition of the need to continue to reach out to adolescents, 18 also suggested the proliferation of peer educator programs or the increased use of teen performing arts groups.

As to CBO-designed HIV/AIDS educational materials, 51 staff members and students voiced a need for updated editions of pamphlets, brochures, posters, and videos that reflected the changing nature of this epidemic. Forty-three individuals also underscored the need for multilingual HIV/AIDS materials, with 28 of them specifically requesting bilingual videos designed for adolescents. Some staff members indicated that they felt so strongly about the need for additional programmatic materials that they had purchased items with their own money when school funds had run out. It was evident that schools needed more assistance in locating, assessing, and securing HIV/AIDS educational materials.*

On the basis of interviews with school staff, students, and parents, OREA evaluators offer the following suggestions to improve the Expanded HIV/AIDS Education Program/Including Condom Availability:

- Encourage and facilitate linkages between schools and community-based and other voluntary HIV/AIDS organizations and agencies. Schools can benefit from the resources of external organizations with expertise in health care, HIV/AIDS, adolescent services, and other related areas. Reciprocally, schools can play an important role in informing students about the services available to them in the community.
- Assist schools in identifying appropriate speakers, especially people with AIDS or those who may be HIV-positive, as well as speakers with medical backgrounds who can provide ongoing information to school staff, students, and parents about the HIV/AIDS epidemic.
- Accelerate the materials review process to provide all schools with adequate and updated publications, videos, and other resources. Ensure that these materials are culturally relevant and in appropriate languages.

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*In response, the HIV/AIDS Technical Assistance Project planned to hire a full-time resource person to improve the procurement of materials during the 1992-93 academic year.

VII. PEER EDUCATION PROGRAM AND BASE GRANTS

BACKGROUND

In the adolescent population, peers strongly influence attitudes and behaviors. Research has shown that the use of peer educators improves the effectiveness of health education programs (CDC, 1991). Program administrators sought ways to improve the knowledge and communication skills of a group of students in high schools in order to ensure that students were disseminating accurate information and promoting responsible behavior.

During the 1990-91 school year, OREA observed training for peer leaders and interviewed both peer educators and their faculty advisers. In 1991-92, 86 high school programs received special BASE (Be Active in Self Education) grants to implement programs addressing adolescent health issues including HIV/AIDS and drug and alcohol prevention. At four of the schools with BASE grants OREA visited, evaluators spoke with both student and staff representatives of grant projects.

PEER EDUCATION PROGRAM

The Peer Leadership program was designed in 1989-90 to train high school and junior high school students to increase their knowledge of HIV/AIDS issues, become mentors in HIV/AIDS education classes, and provide overall leadership in AIDS prevention efforts in their schools. Peer educators received supervision from faculty advisers.

Evaluators attended the general training for all peer educators in the 1990-91 school year, in addition to visiting seven high schools and one junior high school participating in the Peer Leadership program. Some of the high schools were visited both in the planning stages of the program and after program implementation. Evaluators interviewed faculty advisers at all the sites and peer leaders at most of the sites, and observed programs developed by peer leader groups in five of the eight schools visited.

Facilitators divided the training into four parts. The first part was a panel discussion and presentation by four people with AIDS (PWAs). These panel members gave short histories of how they contracted the virus and the impact of the virus on their lives. Student/trainees appeared visibly moved by the presentations, as reflected by their questions about such concerns as how the presenters had been treated by family, friends, and physicians since they found out they were HIV-infected. In the second part of the training, students formed smaller groups and met with members of the HIV/AIDS Education Program staff or outside experts from community-based organizations. Students received specific information about the spread of the HIV virus and raised more questions in these sessions.

These small groups stayed together for the third part of the training, where representatives from the Young Adult Institute, Mt. Sinai Hospital, and the Hetrick-Martin Institute led discussions on subjects such as adolescent sexuality, negotiating condom use between partners, and presenting HIV/AIDS information to teenagers. For the fourth part, peer leaders reassembled in a large group for lunch and a "summing up," in which student-trainees shared what they had learned during the day.

In subsequent interviews virtually all students found the training constructive and worthwhile largely because it introduced the idea of using PWAs as valuable players in HIV/AIDS educational campaigns. Many students commented that they had previously been afraid of people with AIDS, and the training had helped them to see afflicted individuals as real people.

Faculty advisers identified students in each participating school whom they felt would be good candidates for peer leadership groups. Most of the advisers made their decisions through recommendations from teachers and guidance counselors, followed by interviews with students. Student participation was completely voluntary.

In schools where peer leaders taught in the classroom, they met in groups with faculty advisers to gain a more thorough understanding of HIV/AIDS issues and to discuss creative ideas and strategies for implementing HIV/AIDS education. Some advisers arranged for speakers from different community agencies to give presentations to the peer leadership group. Group members viewed videos and reviewed pamphlets to determine those educational resources most appropriate for their specific classes. In many schools, faculty advisers encouraged peer leadership groups to develop their own lesson plans and materials, including skits, videos, educational hand-outs, and audio visuals resources.

All HIV/AIDS peer leaders in second-year programs had the opportunity for significant direct classroom teaching experience. Teams of two to three students opened class presentations by giving up-to-date information about HIV transmission, followed by a short video. They then opened up the classroom for general discussion and questions and answers.

Most peer leadership groups concentrated, however, on disseminating AIDS information outside of traditional classroom settings. All-school fairs, theater presentations, and assemblies were alternative approaches used by peer leaders to raise the HIV/AIDS awareness level of their fellow students. Groups developed a variety of skits, including one that dealt with a star football player who had contracted AIDS and another focusing on the anxieties faced by a student going to a drug store to buy condoms.

Teachers who were interviewed described these skits as successful because they allowed students to face their feelings through fictitious situations. Advisers said that these skits stimulated discussion and brought many students' fears and misunderstandings out into the open.

The peer leadership program also used other forms of media in HIV/AIDS educational efforts. In one school, peer leaders created radio public service "commercials" broadcast in the cafeteria and over the public address system to make students more aware of AIDS issues. These commercials included a rap song promoting the use of condoms, a "pitch" for the importance of exercising responsible decision-making, a message encouraging openness and tolerance for people with different lifestyles, and a warning that anyone can contract HIV. An added feature of these radio broadcasts was that messages were translated into each of the languages spoken in the school.

Peer leader groups were especially interested in reaching different cultural groups and limited English proficient students with HIV/AIDS information. In a number of schools, peer leaders arranged for the translation of relevant literature into Spanish, Chinese, Creole, Korean, and Arabic. Many groups attempted to broaden educational efforts and explore the manner in which different cultures defined and understood the virus.

Peer leader programs averaged between 15 and 20 core members per school over the course of the semester. Although this is a relatively small number, it takes on special importance given the misinformation and fear that exists for so many students with respect to the HIV virus. At some of the schools, students from the peer leadership group also served as members of the school-based HIV/AIDS education teams.*

The program seemed to create a niche for peer leaders both within and outside of school. The training they received enabled them to answer HIV/AIDS questions more effectively than most of their peers and family and even some of their teachers. Many peer leaders wanted students to seek them out to discuss their concerns and questions about HIV infection. As a result, student leaders felt that one of the most important aspects of the program was being visible in the hallways with their HIV/AIDS T-shirts so that other students could approach them. This strong desire to share knowledge was also evident in their willingness to enter classrooms in a pedagogical role. A number of peer leaders said that they never thought they would be able to make a presentation in front of a group but this program made it possible.

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*Out of the 16 schools in Phase I, six were had participated in the HIV/AIDS Peer Leadership pilot program.

Interviews revealed that peer leaders took this same attitude into the community, seeing themselves as important participants in AIDS prevention efforts. One Haitian student described his attempts to share AIDS information with his church. With the help of his faculty adviser, he located educational booklets written in Creole and passed them along to the congregation. Students from another peer leadership group became volunteers in a local hospital ward for AIDS patients. Several peer leaders entering college the following fall expressed an interest in continuing this work on their campuses.

Peer leaders reported that they used their awareness of HIV/AIDS issues in conversations with their families. All students interviewed said they had held discussions with family members--parents, aunts, uncles, cousins, and especially siblings. Several peer leaders communicated feelings of great apprehension and fear about the future for their younger brothers and sisters. Many also expressed concern for how little the adults in their families knew about HIV/AIDS. In at least two instances, however, parents of peer leaders participated in the development of the condom availability plan.

Peer leaders may have had substantial influence on fellow students who had dropped out of school. A number of students described conversations about HIV/AIDS that they had "hanging out" on the corner or at the swimming pool with friends. Peer leaders commented that hearing misinformation about HIV/AIDS was often the catalyst for discussions. Although friends sometimes disagreed with them, peer leaders felt that the level of expertise on HIV issues they had gained from the program made it difficult for their companions to refute their arguments.

BASE GRANT PROGRAM

Over the summer of 1991, eight high school students worked in a six-week salaried position within the Chancellor's Office of External Programs to develop the 1991-92 grant program in peer education. Students met with funding organizations to learn about the grant-making process and designed a poster announcing the creation of the BASE (Be Active in Self Education) grants distributed along with requests for proposals to all schools in October 1991. Student groups, working with a faculty adviser, and in collaboration with the school's HIV/AIDS team, were invited to submit applications for BASE grants of up to $2,500 to support student-led programs addressing adolescent health issues, including HIV prevention and drug and alcohol abuse and prevention.

After review by a committee that included students, central administrative staff, and members of community organizations involved in HIV/AIDS education, 86 projects were funded in 62 schools.* These projects included: interactive theater presentations; designing T-shirts, buttons, flyers, comic books and posters; public service announcements; murals; videos; health fairs; assemblies with guest speakers; and public service projects. A technical assistance conference was conducted in March 1992 for grantee students. Approximately 250 students and their staff advisers attended. The majority of student projects were carried out between mid-March and the end of the school year in June.

Of the ten schools OREA visited, four received BASE grants. Evaluators interviewed students and faculty advisers at each site. At one school, the grant supported a student-produced play that focused on the impact of HIV/AIDS on families. The play was videotaped and used as part of the schoolwide HIV/AIDS educational campaign. Another school used the grant to fund a poster project in which students communicated the importance of protecting themselves from the HIV virus in words, pictures, and other visual images. In one school, students organized a conference bringing together HIV/AIDS peer educators citywide. The grant enabled students to develop publicity materials, invite guest speakers to address the assembly, and attend educational forums outside of school.

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*In the 1992-93 school year, the number of BASE grants increased to 121. Grants were awarded to 80 schools.

Students who were interviewed said that they saw the BASE grant as an opportunity to expand student awareness of HIV/AIDS in the school. Several cited HIV infection of a family member or friend as a reason they wanted to participate in grant activities. At a faculty conference attended by an OREA evaluator, a student working on a BASE grant spoke movingly about her uncle who had died from AIDS. She urged her teachers to do more to support student efforts to prevent HIV infection. In another school, BASE grant meetings benefitted students who were touched by HIV/AIDS. As one student said: "We talk a lot about coping; especially coping with friends who have the virus."

All four faculty advisers believed that the grant had been helpful in supporting the goals of the HIV/AIDS Education Program at their schools. One adviser, whose students had created T-shirts with HIV prevention messages, emphasized how the project generated publicity and made students want to be involved. Another asserted that "it is the most tangible thing that this school has gained from the [HIV/AIDS Education] program." An adviser whose students used the grant to write three scripts for AIDS-related skits, said: "These student-created skits generate discussion, heighten awareness, and increase students' self esteem. Because it is produced by students, other students will listen and pay attention."

Students felt that the project made a difference in increasing awareness of health issues affecting their peers. One expressed the belief that "...we're bringing a lot of ideas that aren't common knowledge" and another remarked, "...since students are getting information from people they know, they pay more attention." Several advisers echoed the importance of the student-to-student aspect of their school's BASE grant program.

CONCLUSIONS AND RECOMMENDATIONS

Peer education has been an important component of the HIV/AIDS Education Program. In 1990-91, peer educators in high schools and junior high schools were trained by the central administration as part of a Peer Leadership program. BASE Grants were initiated in 1992 to expand student involvement in the area of adolescent health with a special focus on HIV/AIDS and drug and alcohol prevention.

On the basis of interviews with peer leaders who received special training and their faculty advisors, OREA evaluators concluded that peer leaders were important sources of factual information about HIV/AIDS for their friends and families. In addition to classroom instruction, peer leaders engaged in other activities to increase HIV/AIDS awareness, including health fairs, skits, public service commercials broadcast in school, and schoolwide assemblies.

BASE Grants provided a vehicle for continued student involvement in health education activities. In 1991-92, under this initiative, 86 projects were funded by a private foundation. Although only four students who worked on grant-funded activities and four faculty advisors were interviewed, participants were very positive about the projects. Student involvement, in some cases sparked by a personal attachment to someone with AIDS, was considered to benefit the student personally. Moreover, the projects benefitted students in their own schools though media outreach and, in the case of the school that held the citywide conference of peer educators, the effects extended beyond the funded school.

With respect to the involvement of students in HIV/AIDS education program, OREA offers the following recommendation:

- Foster involvement of students on the HIV/AIDS education teams and expand opportunities for student involvement in the HIV/AIDS education and awareness activities. Seek funding to expand the BASE Grant Program which provides funding for student-initiated projects. Because students seek each other out for advice and information, and because they have a unique ability to craft prevention messages that will be meaningful to other students, student involvement in planning and programming should be encouraged.

GLOSSARY

Abstinence	Refraining from sexual intercourse (oral, anal, vaginal) and drug and alcohol use.
AIDS	Acquired Immunodeficiency Syndrome
BASE grants	Be Active in Self Education Grants. Privately funded small grants program for student-developed HIV/AIDS and other health-related projects.
BOE	New York City Board of Education
CBO	Community-based Organization
CHC	Comprehensive Health Coordinator
COSA	Coordinator of Student Activities
HIV	Human Immunodeficiency Virus
LEP	Limited English Proficiency
OREA	Office of Research, Evaluation, and Assessment
Over-the-Counter Students	Students who were not in the New York City school system the previous year and therefore not listed on official high school records. These students did not register for school until September or later in the school year.
PE	Physical Education
Phases I-III	Program administrators assigned schools to one of three training sessions conducted on different dates. Similarly, trained staff in these schools implemented condom availability in three waves (or phases) during the 1991-92 school year beginning with the first phase in November 1991.
PPS	Pupil Personnel Services
SPARK	SPARK was founded in 1971 to counter substance abuse with supportive counseling and positive peer influence. SPARK teams in New York City High Schools deliver services to students, school staff, and the community. The SPARK team at most schools is comprised of an Intervention Specialist, Prevention Specialist, Peer Group Specialist, and Alumni Peer Helpers.

STD	Sexually Transmitted Disease
Tiers I and II	Training sessions for members of the HIV/AIDS Education teams developed by the Office of Technical Assistance.

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APPENDIX A

New York City High Schools by Training and Implementation Phase

Phase I

Brooklyn Technical
Bronx Regional High School
City as School
Clara Barton
Curtis
Fashion Industries
Forest Hills
George Washington
John Dewey
Martin Luther King, Jr.
New York Vocational Technical
Richard R. Green
Springfield Gardens
Theodore Roosevelt
University Heights
Walton
William H. Taft

Phase II

Alfred E. Smith
August Martin
Aviation
Brooklyn College Academy
Bronx Comprehensive Night H.S.
Bushwick
Canarsie
Career Education Center
Eastern District
East New York H.S. of Transit Technology
Edward R. Murrow
Far Rockaway
Fiorello H. LaGuardia
Flushing
Fort Hamilton
Franklin K. Lane
George Westinghouse
George W. Wingate
Grace Dodge
Herbert H. Lehman
Hostos
International H.S. at LaGuardia Community College

Phase II, cont.

Jamaica
John Bowne
John Jay
John F. Kennedy
Julia Richman
Liberty
Long Island City
Louis D. Brandeis
Lower East Side Prepl.
Manhattan Comprehensive Night H.S.
Martin Van Buren
Middle College
Midwood
Morris
Murry Bergtraum
New Dorp
Offsite
Pacific
Park West
Pregnant Parents and Teens
Queens Vocational Technical
Samuel Gompers
Satellite
Seward Park
Sheepshead Bay
South Shore
Staten Island Technical
Susan Wagner
Telecommunications
Thomas Edison
Tottenville
Townsend Harris
Washington Irving

Phase III

Andrew Jackson
A. Phillip Randolph
Adlai Stevenson
Automotive
Baldwin Learning Center
Bayside
Beach Channel

Phase III. cont.

Boys and Girls
Bronx High School of Science
Brooklyn Comprehensive Night High School
Cardozo
Central Park East
Chelsea
Christopher Columbus
Concord
DeWitt Clinton
Erasmus
Evander Childs
Franklin D. Roosevelt
Francis Lewis
Fredrick Douglas Learning Center
Grover Cleveland
Harry Van Arsdale
H.S. Division Outreach
H.S. for the Humanities
H.S. of Art and Design
H.S. of Graphic Communication Arts
H.S. Redirection
Hillcrest
James Madison
James Monroe
Jane Addams
John Adams
Lafayette
Mabel D. Bacon
Manhattan Center for Science and Math
Newtown
New Utrecht
Norman Thomas
Park East
Paul Robeson
Port Richmond
Prospect Heights
Queens Comprehensive Night H.S.
Ralph McKee
Richmond Hill
Samuel J. Tilden
Sarah J. Hale
South Bronx
Street Academy
Stuyvesant
Thomas Jefferson
William C. Bryant
William E. Grady

APPENDIX B

Description of the HIV/AIDS Training Modules

The following is a description of the three segments of the New York City Public Schools HIV/AIDS Education training.

Orientation

The initial session, the Orientation, was a half-day of training composed of motivational, informational, and team-building activities. A large-group format was utilized to gather all of the participating schools together in one place at the same time. Its objectives were to:

- create an overall context for the program;
- inspire and motivate team members;
- provide current information about adolescent development and behavior
- increase awareness of the impact of HIV/AIDS on adolescents, families, and communities;
- share information on HIV/AIDS community resources; and
- allow team members to explore their own concerns about the roles they would play in the program.

Orientation activities included keynote addresses delivered by prominent physicians and educators, performing arts presentations by teen groups, and question-and-answer periods with "experts" on HIV/AIDS issues. The entire HIV/AIDS education team from each participating school was invited to attend the orientation.

Tier I Training

The second session, the Tier I training, was a full-day session which covered Board of Education and policies, information on HIV/AIDS, and team-building. It consisted of a series of small group workshops, supplemented by a large-group gathering. The Tier I Training objectives were to:

- continue to motivate team members to implement the program;
- clarify program policies related to HIV/AIDS instruction and condom availability;
- provide current information about adolescent development and behavior;
- increase teams' understanding of HIV/AIDS-related issues; and
- share information about the resources team members bring to the program.

Once again, each school's entire team was invited to attend the Tier I training.

Tier II Training

The third and final session, the Tier II training, was a two-day session consisting entirely of small-group exercises. It focused on program policies, information on adolescent sexual behavior, prevention (including abstinence), and condom use and misuse. Training was specifically designed for the condom availability volunteers, and only full-time New York City public school staff members were permitted to attend.* Attendees from each school generally included the team leader, a school administrator on the team, and the condom availability volunteers.

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*Topics covered in the small groups included: adolescent sexuality; Communicating with teens; teaching sexual abstinence; risky sexual behaviors; condom use and misuse; negotiating with your partner; school system policies on condom availability; and identification and utilization of HIV/AIDS community-based resources.

APPENDIX C

BOARD OF EDUCATION CITY OF NEW YORK

OFFICE OF THE CHANCELLOR

JOSEPH A. FERNANDEZ
CHANCELLOR

MEMORANDUM

March 26, 1991

TO: HIGH SCHOOL SUPERINTENDENTS, HIGH SCHOOL PRINCIPALS, PARENT ASSOCIATION PRESIDENTS, SBM/SDM CHAIRS, UFT CHAPTER CHAIRS, HIV/AIDS EDUCATION TEAMS

FROM: Joseph A. Fernandez
Chancellor

SUBJECT: Expanded HIV/AIDS Program Implementation Guidelines

Attached are guidelines for program implementation of the Expanded HIV/AIDS Program Including Condom Availability. These guidelines were devised in consultation with high school principals, health educators, and guidance staff. Please do not hesitate to call on my staff if we can be of any assistance. Individuals and their numbers are included in the guidelines.

I want to thank everyone who has been involved in this process and wish you great success in developing individual school plans. You have my full support.

JAF:sw
Attachment

NEW YORK CITY PUBLIC SCHOOLS • 110 LIVINGSTON STREET • BROOKLYN, NEW YORK 11201

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CHANCELLOR'S EXPANDED HIV/AIDS EDUCATION PROGRAM INCLUDING CONDOM AVAILABILITY IMPLEMENTATION GUIDELINES

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GUIDELINES FOR HIV/AIDS PROGRAM IMPLEMENTATION IN THE HIGH SCHOOLS

INTRODUCTION

On February 27, 1991 the New York City Board of Education held a historic vote in favor of a bold new plan for Expanded HIV/AIDS Education Including Condom Availability in the high schools. The intent of the plan is to raise awareness about HIV/AIDS and encourage students to abstain from high risk behavior, including sexual intercourse and substance abuse. What follows are the guidelines for implementing this program.

Every high school is required to develop its own school-based plan for program implementation. That plan should describe each school's HIV/AIDS Education program including the strategy for making condoms available. All support services that impact the plan should be included and, to the extent possible, representatives from those programs should be included in each school's HIV/AIDS Education Team. For those who are interested, there will be a technical assistance meeting for schools to provide assistance in completing their plans. This will take place on April 12, 1991 at Junior High School 17, 328 West 48 Street, New York, New York at 9:00 a.m.

A timeline for training and implementation is included. A sample format of the plan is attached.

If there are questions about any aspect of this document, please call:

Larry Edwards, Director of Office of Access and Compliance, Division of High Schools, (718)935-3415

Jerome Rosenzweig, Acting Director, Office of Health, Physical Education, and School Sports, Division of Instruction and Professional Development, (718)935-4140

Georganne Del Canto, Assistant Director, Office of Health, Physical Education and School Sports, Division of Instruction and Professional Development, (718)935-4140

If assistance is needed in identifying interagency resources for plan development, please call Sarah Williams, Coordinator of External Resources, Office of the Deputy Chancellor for External Programs and Community Affairs, (718)935-2778.

I. TEAM DEVELOPMENT

MANDATE 1:

Every high school is required to form or expand its HIV/AIDS Education Team. Participants must include but are not limited to the following:

- **Principal;**
- **Assistant Principal;**
- **Teachers--there must be one, and preferably more than one, teacher on each team;**
- **Parents--there must be at least one, and preferably more than one, parent on each team;**
- **Students--there must be at least one, and preferably more than one, student on each team;**
- **Health Resource Staff--the individuals who volunteer and are trained to make condoms available are required to be members of each team.**

Teams should be extended to other members of the school community including, but not limited to, supervisors, deans, social workers, guidance counselors, SPARK counselors, special education staff, school-based clinic personnel, health aides, paraprofessionals, and school security personnel.

From this team, a leader or facilitator must be established. Efforts should be made to accommodate meeting times for all team members. In SBM/SDM schools, a liaison should be established between the HIV/AIDS and the SBM/SDM teams. Responsibilities for the composition of the team and success of the school program rest with the principal.

In addition, the importance and value of integrating other school health efforts into this program cannot be stressed enough. Members of the broader community who have expertise in the areas of health, teen sexuality, and HIV/AIDS are encouraged to be included. Each plan should list team members and titles as well as describe how other programs and services will be integrated to provide a comprehensive plan.

Role of Team:

The HIV/AIDS team will be the primary facilitators and planners of HIV/AIDS education in their schools. Each plan must describe how the role of the team is defined and, specifically, its responsibilities. Suggestions for team activities include:

- drafting a statement outlining the team's role in the school and a year-to-year plan;
- assuming responsibility for reviewing resource materials to be used as part of the HIV/AIDS initiative for their appropriateness and quality;
- identifying who should teach the HIV/AIDS lessons (see section on Instruction and Curriculum);
- recruiting, and incorporating outside agencies into the school's HIV/AIDS program;
- defining and enforcing a policy for maintaining the confidentiality of students who obtain condoms;
- creating the calendar of HIV/AIDS education activities for the school year;
- outlining an internal assessment process for the program;
- identifying on-site counseling services for students or establishing a referral process to outside agencies that provide these services. In addition to the whole range of support programs, counseling services should include those specifically related to HIV/AIDS such as testing for HIV, bereavement counseling, HIV/AIDS support and treatment programs, etc.

II. INSTRUCTION AND CURRICULUM

MANDATE 2:

Each plan must state how, in each grade, the required six lessons on HIV/AIDS will be taught.

Attached is a copy of the current curriculum for grades 9-12. These lessons can be taught in a variety of ways including through social studies, health, or science. School plans should reflect an effort to integrate the subject of HIV/AIDS instruction into as many content areas as possible.

The current 7-12 HIV/AIDS curriculum is being revised and a draft should be available for review in the Fall of 1991. Training that includes information on the new curriculum and the specifics of the condom availability component will be provided. According to the State Commissioner of Education's Regulations on HIV/AIDS Education (Subchapter G, part 135), before the curriculum is taught parents must be informed of their right to opt their child out of prevention lessons. If a parent chooses to opt their child out, they must submit in writing a statement that ensures that they will provide the same information to their child at home. Parents cannot opt their children out of the condom availability component of the HIV/AIDS program.

III. LOCATION OF CONDOMS AND OTHER HEALTH RESOURCES

MANDATE 3:

Each school is required to designate at least one area within the school (not the school-based health clinic) where condoms and other health resources will be made available. The space should offer privacy and should be outfitted with information on HIV/AIDS, sexually transmitted diseases, and other health issues.

If health materials are needed, please contact John Torres, AIDS Resource Center, (212)385-2704. There may be additional sites where condoms can be made available such as the guidance counselor's office. If more than one site is identified, please explain what health resources will be available at each site.

Because of technical issues, school based health clinics cannot make condoms available at this time. Efforts are underway to resolve this issue with the New York City Department of Health and the Board of Education. It is expected to be addressed before September, 1991. Those schools that have clinics can include in their plans their intention to use this site for condom availability in the future, pending Board approval. Schools will be kept posted on the status of this issue.

MANDATE 4:

The health resource site must be staffed at least ten periods each week at a variety of times during the school day.

Schools are encouraged to arrange more staffing time if possible. Condoms can also be made available before and after school and at additional times that are easily accessible to students.

Each condom will be accompanied by the manufacturer's pamphlet explaining correct usage. A videotape will also be made available that demonstrates condom use.

MANDATE 5:

After condoms are delivered to the school, the school is responsible for their security. Each school's plan must include a method of locking and storing the condoms to prevent tampering and damage.

MANDATE 6:

The schedule of the health resource space hours must be posted and accessible to all students. Each school's plan should describe the method for communicating this schedule to the students.

IV. CONDOM AVAILABILITY STAFF

MANDATE 7:

At least one male and one female volunteer must be identified to make condoms available.

These individuals will be responsible for providing condoms upon request and answering questions based on the training they have received. For support services personnel who volunteer, staffing a health resource site may be incorporated into their ongoing responsibilities. For teachers with full teaching loads who volunteer to staff the health resource site, there are several options for scheduling. A schedule could be established for teachers to use their professional period, in some cases their building period, or other mutually agreed upon times.

Volunteers must perform their responsibilities in accordance with the guidelines established by the New York City Public Schools and set forth in an approved plan. A thorough review of all legal issues will be included in the training for the condom availability volunteers.

Individuals who have volunteered to staff the health resource sites will receive ongoing technical support and have group meetings coordinated by the Office of Health, Physical Education, and School Sports.

V. STUDENT ORIENTATION

MANDATE 8:

Schools will be required to inform every student, including over-the-counter registrants and students whose home language is other than English, about all services provided on the school site, including the availability of condoms and counseling, names of staff who have volunteered to staff the health resource site(s), and members of the HIV/AIDS team. Each school's plan should describe the process for conveying this information.

The expanded HIV/AIDS Education Program should have as its primary emphasis the importance of abstaining from risk behaviors including sexual intercourse and substance abuse. Condom availability must be placed in this broader context. Students must understand the implications of their actions and the potential consequences of engaging in high risk behaviors.

The condom availability component cannot be implemented until school staff have successfully completed the training and students have received orientation as to the role and resources of the health resource site.

VI. PARENTS

MANDATE 9:

Schools must provide a HIV/AIDS information session for parents.

Organized in conjunction with each school's Parents' Association, the HIV/AIDS team members, and any additional parents with expertise in the health field, this forum should include basic information on HIV/AIDS transmission and suggestions for parents on how to discuss difficult issues with their children. Information for parents whose home language is other than English should be included in the presentation. The Chancellor's Office will arrange for support in implementing this forum. For assistance in securing speakers and facilitators for these programs, please call Sarah Williams, Coordinator of External Resources, (718)935-2778.

VII. WAIVERS

Reasonable requests for waivers from the mandates of this plan will be entertained. If a school requests a waiver from any of the mandated components, the reasons why a waiver is sought should be included. Requests will be considered in the context of a school's overall plan to improve the quality of HIV/AIDS education in the school.

VIII. MONITORING AND EVALUATION

Each team is responsible for determining a method of internal assessment for their HIV/AIDS Education Program. The purpose of the assessment is for each school to set its own standards and measurements for how their HIV/AIDS Education Program is operating and ways it could be improved.

In conjunction with the Office of Research, Evaluation, and Assessment, the Office of Monitoring and School Improvement will monitor and document the implementation of the Expanded HIV/AIDS Education Program.

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TEAM RESOURCES AND SUPPORT TIMELINE

Deadlines

Two deadlines have been established for the submission of the HIV/AIDS Education Plan:

May 1, 1991

June 3, 1991

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The schools that submit plans by May 1, 1991 will be notified by June 1, 1991 about whether their plan has been accepted for implementation. There will be an orientation in June for those teams whose plans are accepted. Schools that submit plans by June 3, 1991 will be notified in September. For these teams, the orientation will be offered in September. The full training for team members with approved plans will begin in October, 1991.

Training

After each school's plan is submitted, training and support will be provided to each team in the following ways.

Orientation

This orientation will provide an overview of the program as well as an opportunity to share information and strategies with other schools. Topics will include: a discussion of model plans, preliminary team building exercises, and the role and responsibilities of the team.

Tier I Training

Tier I training will be offered for the HIV/AIDS Education Teams. All team members including students, are required to attend. The session will be scheduled during a school day between the hours of 9:00 a.m. and 3:00 p.m. If parents are unable to attend, an additional training will be scheduled to accommodate them. Topics to be covered in Tier I training include:

- an overview of the epidemic;
- teen sexuality;
- behavioral issues of youth;
- key elements of the curriculum;
- resource referral information and strategies;
- team building exercises;
- politics of implementation.

Tier II Training

Tier II training is for the individuals who will staff the health resource locations and give condoms to those students who request them. For schools that submit approved plans in May of 1991, Tier II training will be offered in October. For those schools that submit approved plans in June, Tier II training will be offered late in the fall of 1991. Through the intensive 9:00 a.m. - 3:00 p.m. two day training, volunteers will learn very specific information on HIV/AIDS, adolescent sexuality, resource referral, multicultural sensitivity, behavioral issues for teens, condom usage, and techniques for addressing sensitive topics with teens.

EXTERNAL RESOURCES

As mentioned earlier, health leaders in all fields have offered their assistance in implementing this program. The Office of the Chancellor has also worked to identify additional community-based organizations, academic institutions, and service providers that have experience and are interested in assisting schools. As a result, many resources are available as teams work to formulate and implement their plan. The following is a partial list of expertise and support activities from which teams may draw:

- the New York City Department of Health: training programs, in partnership with the New York City Public Schools; and directories of community based organizations available to work with schools;
- the New York City Health and Hospitals Corporation: advice, technical assistance, and referrals;
- the Food and Drug Administration: brochures and literature on HIV/AIDS;
- medical schools and hospitals: assistance with training, speakers for school forums, or "adopting" a school and serving as an advisor to an HIV/AIDS team;
- videotape on appropriate condom use;
- not-for-profit organizations with health programs for referrals and facilitators to assist with planning;

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EXTERNAL RESOURCES (CONT'D)

- speaker's bureaus with health experts to address parents at school forums or conduct workshops on the issue of HIV/AIDS.
- the American Foundation for AIDS Research: Resource Directories and possible training and technical assistance for program implementation;
- a small grants program for student developed projects on health and HIV/AIDS education (available January 1992)*;
- technical assistance provided by a not-for-profit health organization with private foundation support**;

A memo is being drafted on suggested screening procedures to help teams evaluate the appropriateness and educational value of the activities of outside organizations. It will be sent to you this spring.

* In April of 1991, the Chancellor will formally announce the establishment of the Health HIV/AIDS Fund for the New York City Public Schools. This Fund, established with grants from foundations and corporations, will provide small grants (up to $2500) for student-developed education projects that increase student and community awareness of health and HIV/AIDS issues.

** With a grant from the Aaron Diamond Foundation and in collaboration with the New York City Department of Health, the Office of the Chancellor is developing a program that will provide professional health advocates and technical assistance to high schools as they begin implementing their plans. This service will be available in the fall of 1991. Further information will be provided as it becomes available.

APPENDIX D

MEMORANDUM

April 25, 1992

TO: HIGH SCHOOL PRINCIPALS, HIV/AIDS EDUCATION TEAM LEADERS, COMPREHENSIVE HEALTH COORDINATORS, TECHNICAL ASSISTANCE STAFF, and SUPERINTENDENTS' LIAISONS

FROM: John Schoener
Chief Administrator, Office of Research and Evaluation

SUBJECT: HIV/AIDS Team Self-Assessment Survey

As you know, the HIV/AIDS Education Team in each school is required to assess its own HIV/AIDS Education Program. The purpose of this assessment is to have each school set its own objectives, measure how its program is operating, and identify successful strategies as well as ways to strengthen the program.

In response to requests by schools for guidance in conducting self-assessments, the Office of Research, Evaluation, and Assessment (OREA) has developed the attached survey instrument. Covering all major aspects of the Expanded HIV/AIDS Education Program, this instrument complements the information schools may be collecting with the Health Resource Encounter Log and Monthly Encounter Report that was recently disseminated to HIV/AIDS teams.

Designed in consultation with program staff, Technical Assistance staff, Comprehensive Health Coordinators, Superintendents' Liaisons, and school staff, the Self-Assessment Survey instrument can help schools review their HIV/AIDS Program activities and plan for next year. These questions can help schools assess their strengths and lead to constructive problem-solving where weaknesses are identified. In addition, completion of this survey will provide important historical program documentation. Such information can be extremely useful to have on file for a new school administrator or new members of an HIV/AIDS team.

Although schools are not required to submit self-assessment findings to the central administration, these findings would greatly assist OREA's efforts to document the program and assess its implementation during the 1991-92 school year. Therefore, OREA is requesting that schools send written responses to a subset of relevant questions and/or findings of other self-assessment efforts. Aggregate findings will be used to inform program planning and policy development.

OREA purposely identified a large number of questions organized under the following five program categories: General Issues, HIV/AIDS Education Team, Curriculum, Health Resource Room and Condom Availability, and Parent Involvement. Schools can select the categories or questions they believe are most relevant to their self-assessment needs and/or substitute their own.

We suggest that HIV/AIDS teams meet to discuss these self-assessment questions at the end of the school year. One or more team members can be assigned as recorders. Written responses, based on recorders' notes, can be reviewed by team leaders and selected team members, and revised. If you choose to send findings to OREA, please refer to the question numbers when responding to OREA's questions.

Mail self-assessment findings by June 30th to:

Lori Mei, Ph.D.
New York City Board of Education
Office of Research, Evaluation, and Assessment
110 Livingston Street, Room 740
Brooklyn, NY 11201

Copies of the OREA report will be sent to all HIV/AIDS Education Teams.

If you have any questions about the Self-Assessment Survey, you can contact me at (718) 935-3763 or contact Linda Simkin or Peggy Lane at (718) 935-3772.

c: Carmen Valera-Russo
Nilda Soto Ruiz
Georganne Del Canto
Larry Edwards
James Healy
Jill F. Blair
John DeMelio
Barbara Whitney
Robin Willner

Expanded HIV/AIDS Education Program Including Condom Availability

School____________________________ Superintendency _______________

Name of contact person ____

Telephone number ____

INSTRUCTIONS

This survey is designed to be completed by HIV/AIDS Education Teams at the end of the 1991-92 school year. Teams should respond to those questions most relevant to their programs. Other questions can be substituted.

Because schools can choose from these questions or substitute their own, we have not left room for responses on the attached survey. Please use this cover sheet and as many additional sheets of paper as needed and refer to the OREA question number if you respond to any of the OREA questions.

Schools sending responses to OREA can be assured that information will be considered confidential. Responses will not be identified with any school in OREA's year end report. For administrative purposes, however, we request that you complete this cover sheet so we will know the names of responding schools and who to contact in case any clarification of responses is needed.

Send completed responses by June 30th to:

Lori Mei, Ph.D.
New York City Board of Education
Office of Research, Evaluation,
and Assessment
110 Livingston Street, Room 740
Brooklyn, NY 11201

SELF-ASSESSMENT SURVEY

1. GENERAL ISSUES

1.1 What were your major accomplishments this year in implementing the Expanded HIV/AIDS Education Program Including Condom Availability?

1.2 What are the major obstacles to the success of the program? How can these obstacles be addressed?

1.3 To what degree is the Expanded HIV/AIDS Education Program coordinated with other school-based programs such as drug and alcohol prevention, attendance improvement/dropout prevention, health services, and pregnancy prevention? What factors have facilitated or impeded coordination?

1.4 What, if any, community-based organizations (e.g. youth programs, settlement houses, medical schools, colleges, social service organizations) were involved in your program? What is your assessment of the involvement of these organizations? Have you encountered any barriers to involving outside organizations in your program? If so, how were they or can they be addressed?

1.5 What activities, if any, were conducted or planned to reach students who are at highest risk for HIV infection? How successful were they?

1.6 What special programs and/or activities (e.g., peer education, theater productions, health fairs) has your school conducted to increase awareness about HIV/AIDS? How effective were they?

1.7 Has there been visible community support or opposition to the program? If yes, what form has it taken? What has been the impact on your program?

1.8 Did your school apply for a B.A.S.E. (Be Active in Self-Education) Grant? If not, why not? If yes, was the B.A.S.E. Grant helpful in supporting your program objectives? How was the team involved in the B.A.S.E. grant?

2. HIV/AIDS EDUCATION TEAM

2.1 What activities are conducted by your HIV/AIDS Education Team?

2.2 How often does the team meet? Is this frequency sufficient to accomplish your objectives?

2.3 What factors have facilitated your team's work to date? What factors have impeded it?

2.4 How has your team attempted to build cohesiveness, trust, expertise, or effectiveness? What "team building" methods have been effective?

2.5 Are any groups unrepresented or underrepresented on your team (e.g., teachers, administrators, parents, students, CBOs)? If so, what strategies might increase representation of these groups?

2.6 Does the composition of your team reflect the composition of your school in terms of race, ethnicity, and gender? If not, has this compromised the effectiveness of your team? If the composition of your team is a problem, what can be done to address this problem?

2.7 What provision, if any, has your school made to offer ongoing HIV/AIDS training to staff, students, and parents?

2.8 What is the role of parent members on the HIV/AIDS team? Is the level of parent involvement on the team sufficient? How can parent involvement on the team be enhanced?

2.9 What is the role of students on the team? Is the level of student involvement on the team sufficient? How can student involvement on the team be enhanced?

2.10 What factors may have an impact on team composition for next year? How can you plan for any anticipated changes?

2.11 What ideas do you have to improve the functioning of your team?

3. CURRICULUM

3.1 How are the 6 required HIV/AIDS lessons taught in your school? (For example, are lessons taught in subject classes, gymnasiums, or assemblies? What were the strengths and weaknesses of your school's approach?

3.2 Who teaches the lessons? For example, are lessons taught by your own faculty/staff or professionals from the community? What percentage of classes were taught by school faculty or staff; what percentage by outside resources such as community-based organization (CBO) staff or health professionals.

3.3 Were HIV/AIDS curriculum materials available in the languages you needed? Were you able to obtain adequate supplemental resources such as videos or printed materials?

3.4 Were HIV/AIDS lessons delivered in subject areas (such as health education, science, social studies) ? What was your school's experience with regard to integrating the lessons into these subject areas?

3.5 What training or preparation did your teachers receive this year with regard to the HIV/AIDS curriculum? Is additional training needed? If yes, what type and for whom?

3.6 Were any special provisions made for teaching HIV/AIDS lessons to students who may be particularly difficult to reach (e.g. over-the-counter students, those with limited English proficiency, special education students, or chronic absentees)? If yes, what were they and were they effective?

3.7 Do you have any additional ideas for improving HIV/AIDS instruction in your school?

4. HEALTH RESOURCE ROOM AND CONDOM AVAILABILITY

4.1 How did you inform students about where and when condoms would be available (e.g. posters, PA announcements, brochures, explanations about what goes on in the health resource room)? Were some methods more effective than others? Why?

4.2 When and where are condoms made available to students? Do students seem to prefer obtaining condoms at a particular time of day or location?

4.3 How many Health Resource staff (volunteer staff who make condoms available) do you have? How many are male, how many female? Are Health Resource staff similar to your student population in terms of race and ethnicity? How does their gender, race, ethnicity, or sexual orientation affect students' comfort in asking for condoms?

4.4 How comfortable and knowledgeable are the Health Resource staff in counseling, responding to student questions, and making condoms available to students? What can be done to support Health Resource staff in their roles?

4.5 What factors appear to influence student requests for condoms?

4.6 What, if any, issues, situations, or questions were the Health Resource Staff unprepared to handle either directly or though referral? What can be done to address these concerns?

4.7 What information and materials are available in your health resource site?

4.8 What barriers have you encountered to setting up health resource sites? What additional resources or materials would be helpful?

4.9 What system have you established for ordering condoms and distributing them to health resource staff? How has this worked?

4.10 How have you ensured the safety of condoms? What, if any, problems have been encountered with storage? How were they addressed?

4.11 What does your team see as the most important outcomes of the condom availability aspect of the HIV/AIDS program?

5. PARENT INVOLVEMENT

5.1 What special activities were conducted in your school to acquaint parents with the Expanded HIV/AIDS Education Program Including Condom Availability? Who sponsored these activities? What were the strengths and weaknesses of these special activities?

5.2 Are parents kept sufficiently informed about the HIV/AIDS team's activities? How can team communication with parents be improved?

5.3 What factors have facilitated or impeded parent involvement in the HIV/AIDS program? How can parent involvement be enhanced?

5.4 Is there parental opposition to the Expanded HIV/AIDS Education Program in your school? What have been the most effective ways to handle such opposition?

5.5 Is there active, visible parental support? How has this support been developed or utilized?

APPENDIX E

AIDS Supplement to the Family Living Curriculum

Lesson 1: What is AIDS? This lesson is designed to help students define AIDS and identify why AIDS is hard to "catch." Students learn the definition of the words "Acquired," "Immune," "Deficiency," and "Syndrome."

Lesson 2: How can we deal with the fears about AIDS? The objectives for this lesson are for students to recognize that ignorance produces fear and to explain why individual responsibility is important in reducing fear.

Lesson 3/Grade 8: What can families and the community do to help people with AIDS? From this lesson students will be able to identify how families and friends can help connect people with AIDS to community support groups. The lesson's objective is also to identify needs that can be met only with community assistance.

Lesson 3/Grade 9: How does HIV infect the body? From this lesson, students will be able to identify the cells affected by HIV infection and explain why HIV infection is permanent.

Lesson 3/Grade 10: What happens when HIV infects the body? This lesson is designed for students to review the development of the disease and to be able to understand how co-factors affect the development of the virus.

Lesson 3/Grade 11: What happens when HIV infects the body? This lesson is geared to help students understand why HIV infection is so hard to combat and to learn more about different treatment modalities for AIDS and HIV.

Lesson 3/Grade 12: How does HIV affect the body? This lesson will enable students to explain the HIV chain of infection and identify how the HIV chain of infection can be broken.

Lesson 4/Grade 8: What role can each person take in preventing the spread of HIV infection? From this lesson, students will be able to identify high risk behaviors, identify the possible consequences of high risk behaviors, and describe the ways high risk behaviors can be eliminated.

Lesson 4/Grade 9: What can families and the community do to help people with AIDS? This lesson is geared to help students identify how families and friends can help people with AIDS cope with physical, emotional, and economic needs. In addition, it attempts to help them identify needs that can be met only with community assistance and research community resources that can offer help to people with AIDS and their families.

Lesson 4/Grade 10: What can families and the community do to help people with AIDS? This lesson is an extension of Lesson 4 for Grade 9 with a more in-depth discussion.

Lesson 4/Grade 11: What can families and the community do to help people with AIDS? Students will be able to identify the problems that emerge for families and communities, analyze factors that may contribute to community reaction, and explain ways that they as individuals can contribute to building community support for people with AIDS and those who are HIV-positive.

Lesson 4/Grade 12: What can families and the community do to help people with AIDS? Students will be able to identify a role they can take to expand the knowledge and awareness of AIDS in their families, in their communities, and among their peers. As part of the final lesson in this sequence, students will develop a plan to establish an AIDS hotline or peer counseling service.

Lesson 5/Grade 8: What happens when HIV infects the body? From this lesson, students will be able to identify the cells affected by HIV infection, distinguish among AIDS, ARC, and asymptomatic infection, and explain how a person can transmit HIV even though he or she may look and feel well.

Lesson 5/Grade 9: What role can each person take in preventing the spread of HIV infection? This lesson is designed to help students recognize that they have choices as well as responsibilities in the fight against the spread of HIV infection and to give them "hands on" experience in deciding on a course of action in a hypothetical risk situation.

Lesson 5/Grade 10: What role can each person take in preventing the spread of HIV infection? An extension of Lesson 5/Grade 9 with different exercises.

Lesson 5/Grade 11: What role can each person take in preventing the spread of HIV infection? Same goals as the above two lessons with more sophisticated role play exercises.

Lesson 5/Grade 12: What role can each person take in preventing the spread of HIV infection? Same goals as the above three lessons with more sophisticated role play exercises.

Lesson 6/Grade 8: What are some of the human rights issues raised by AIDS? Students will be able to recognize some of the emotional reactions provoked by the AIDS crisis and identify the potential damage often caused by uninformed emotional responses to the AIDS crisis.

Lesson 6/Grade 9: What are some of the civil rights issues raised by AIDS? In this lesson, students will learn to define and identify civil rights and explore some of the issues raised by a hypothetical case study of whether to admit a student with AIDS into a school.

Lesson 6/Grade 10: What are some of the civil rights issues raised by AIDS? From this lesson, students will be able to discuss the reasons for testing for HIV and discuss the reasons why someone would not want to be tested. In addition, they will also learn to identify pre- and post-test counseling.

Lesson 6/Grade 11: What are some of the civil rights issues raised by AIDS? Students will be able to identify the HIV testing issues that they may face in their future and explore possible positions they might take if faced with HIV testing as a pre-requisite for a job.

Lesson 6/Grade 12: What are some of the civil rights issues raised by AIDS? In this last lesson, students will be able to: summarize some of the civil rights issues involved in administering the screening test and explain why the New York City Department of Health finds that the general public would receive no benefit from public identification of people with AIDS or of people infected with or exposed to the HIV virus.

APPENDIX F

SPARK Presentations for At-Risk Behavior

Lesson 1: What are HIV and AIDS? The aim of this lesson is to discuss why teen are at risk for getting HIV and AIDS. Students learn what constitutes safe and unsafe behavior and also become familiar with an AIDS related vocabulary list.

Lesson 2: Refusal Strategies for AIDS Prevention. The goals of this lesson are to review the value of using refusal skills to prevent the transmission of HIV and other STDs and practice some basic refusal skills for use in high risk situations. By the end of the lesson students will be able to:

- Identify the two highest risk behaviors for contracting HIV.
- Name at least three reasons why an adolescent might choose to refuse or postpone intercourse.
- State at least two convincing arguments for refusing or delaying intercourse.
- Explain why the use of drugs or alcohol can contribute to unsafe sexual behavior.
- Describe at least two ways to refuse drugs or needle sharing.

Lesson 3: Risk Reduction Strategies for AIDS Prevention. The main goal of this lesson is to help students understand how adolescents can reduce or eliminate the risk of contracting HIV/AIDS.

The behavioral objectives of the lesson are: to describe a high risk situation that would place an adolescent at risk for contracting HIV, state at least three persuasive arguments for using risk reduction strategies, explain why the proper use of a condom will reduce but not eliminate the risk of HIV transmission for people who have intercourse, and name at least two reasons why teens can benefit from talking to their parents about reducing their risk of getting HIV.

Lesson 4: AIDS and the Family. Goals of this lesson are: to understand how the entire family is affected when a family member is HIV-positive or has AIDS and to become aware of community resources which offer services to adolescents confronting AIDS-related issues in the family. By the end of the lesson, students will be able to:

- List at least three ways family members may be affected when a family member has HIV or AIDS.
- State at least three symptoms of bereavement and loss.

- Name at least two ways an adolescent can support a friend who is experiencing bereavement and loss.

- Identify at least three community resources offering services to people with AIDS and their families.

Lesson 5: HIV and Stress Management. The goal of this lesson is to explore options for reducing stress related to HIV and AIDS. The behavioral objectives for the lesson are to:

- Name at least three strategies for stress management and stress reduction.

- List at least three reasons why an adolescent might consider getting tested for HIV.

- State at least two positive and negative potential consequences of getting tested for HIV.

- Name at least one community resource that can provide AIDS-related services to adolescents.